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NO. _____

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

TEXAS MEDICAL ASSOCIATION, et al.,
Petitioners,

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, et al.,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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September 15, 1989

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QUESTIONS PRESENTED

Whether the federal courts have jurisdiction to review instructions from the Secretary of the United States Department of Health and Human Services to the Medicare Part B carrier that are clearly expressed to the carrier without being promulgated as formal regulations or Medicare Carriers Manual instructions. Specifically, whether under this Court's holding in *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), the federal courts have jurisdiction to review the Secretary's informal instructions or directions to the carrier, treated as binding by the carrier.

Whether a trial court, in dealing with a preliminary injunction, is precluded by 42 U.S.C. § 1395ff from accepting provisional jurisdiction pending evidentiary development of the jurisdictional requisites set forth in *Michigan Academy*.

LIST OF PARTIES

The parties to the proceeding below were:

Petitioners

Texas Medical Association
Travis County Medical Society
Texas Academy of Family Physicians
Texas Ophthalmological Association
Texas Society of Internal Medicine
Texas Osteopathic Medical Association
Earl D. Bellamy, M.D.
Leslie L. Cortes, M.D.
Karlan June Lockey Downing, M.D.
Pablo Garza, M.D.
James M. Graham, M.D.
John M. Haley, M.D.
Craig K. King, M.D.
William E. McCaleb, III, M.D.
San Antonio Medical Associates
Roberto San Martin, M.D.
Gordon W. Scott, M.D.
Robert Frank White, M.D.
Maggie M. Moore
Cleo Marie Gossett
Madeline C. Miles
Rhoda F. Dodson
Pauline K. Richey
Henrietta C. Geren
Raymond Conley, Community Administrator of the Estate of Ovetta Conley, Deceased

Respondents

Louis W. Sullivan, M.D., Secretary, U.S. Department of Health and Human Services

Blue Cross and Blue Shield of Texas, Inc.*

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* The district court dismissed Blue Cross and Blue Shield of Texas, Inc., after an interlocutory appeal was filed with the court of appeals; however, the court of appeals continued to treat Blue Cross and Blue Shield of Texas, Inc., as a party. *See* 875 F.2d 1160, 1164 n.12.

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Petitioners,

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES, et al.,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

The Texas Medical Association and the other Texas physicians' organizations, physicians, and Medicare beneficiaries named as parties petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit.

OPINIONS BELOW

The order of the district court, dated November 2, 1987, granting preliminary injunction, is reported at 678 F.Supp. 643 (Appendix D). The supplemental order of the district court, dated January 8, 1988, containing findings

of fact and conclusions of law in support of the preliminary injunction, is unreported. (Appendix E). The opinion of the court of appeals, dated June 27, 1989, is reported at 875 F.2d 1160. (Appendix A).

JURISDICTION

The court of appeals entered its judgment on June 27, 1989, and denied Petitioners' petition for rehearing on July 27, 1989. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS AND REGULATIONS INVOLVED

42 U.S.C. § 1395u(a)(1) and (b)(3), 42 U.S.C. § 1395ff (1985), 42 U.S.C. § 1395gg(c), 20 C.F.R. § 404.989, 42 C.F.R. §§ 405.350,.355, 42 C.F.R. § 405.501-.502, 42 C.F.R. § 841(b), and 42 C.F.R. § 405.860 are reproduced in Appendix G. Also involved and reproduced in the Appendix G are Medicare Carriers Manual ("Manual") § 12016A and Manual §§ 7102 and 7103.1A as amended by Manual Transmittal No. 1316 (July 1989).

STATEMENT OF THE CASE

The court of appeals vacated the preliminary injunction entered by the district court, which enjoined a Medicare recoupment, and ordered that the action be dismissed for want of jurisdiction. The court of appeals decided that the instructions or directions given by the Secretary to the carrier, which gave rise to the recoupment, were not "regulations" or "instructions" of the sort held by this Court to be reviewable in *Michigan Academy*, and that

judicial review of the Secretary's conduct was therefore barred by 42 U.S.C. § 1395ff. Petitioners sought rehearing on the grounds, first, that the court of appeals was incorrect in concluding that the Secretary's instructions were non-binding and non-reviewable and, second, that the court of appeals incorrectly ordered that this action be dismissed for want of jurisdiction rather than permitting the litigants to develop and present evidence on the nature of the Secretary's instructions. The court of appeals denied rehearing.

A. Regulatory Background

Medicare Part B pays for services that physicians furnish to Medicare beneficiaries. It is administered on a day-to-day basis by private insurers, called "carriers." 42 U.S.C. § 1395u(a). Blue Cross and Blue Shield of Texas, Inc. ("Blue Cross") administers the program in Texas under contract with the Secretary, who acts through the Health Care Financing Administration ("HCFA").

The amount of a Medicare payment for a physician's service is based on the carrier's determination of what constitutes a "reasonable charge" for the physician's performance of a particular medical procedure. 42 U.S.C. § 1395u(b) and 42 C.F.R. § 405.501(a) (1985). Each medical procedure is defined and assigned an identifying number, called a "procedure code." The preferred method of determining a physician's "reasonable charge" involves comparisons of each physician's "customary" charges for a given procedure with "prevailing" charges for that service in the geographic area, but the carrier has discretion in employing a number of methods of developing reasonable charges. 42 C.F.R. § 405.502(a) - (c) (1985).

When a claim is made for a Part B service, the carrier processes the claim and pays the reasonable charge. Detailed rules and instructions govern the carrier's correction of processing and payment errors. Where a claim is more than one year old, the carrier may reopen paid claims only upon the establishment of "good cause" to do so. 42 C.F.R. § 405.841(b). "Good cause," as pertinent here, means the discovery of "new and material evidence." 20 C.F.R. § 404.989(a)(1). In addition, recoupments may not be demanded of a person who was "without fault" in causing the overpayment, where such demand would be against equity and good conscience or would contravene the purposes of the Medicare program. 42 U.S.C. § 1395gg(c), 42 C.F.R. §§ 405.350 and 405.355.

The carrier adjudicates disputes over the amount of Medicare Part B payments through the use of carrier hearing officers, whose authority in adjudicating such disputes is narrowly circumscribed. 42 U.S.C. § 1395u (b)(3)(C) (1985). While the hearing officer is an independent trier of fact, he is required to comply with all *regulations, "policy statements, instructions* and *other guides* issued by the [HCFA]." (Emphasis added). 42 C.F.R. § 405.860. One of these guides is the Manual, which provides that the hearing officer may not interpret the law "in a way different than HCFA does." Manual § 12016A. As to disputes over the amount of a claim, the hearing officer's decision is final.[1]

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1. Since this action involves claims for services furnished before January 1, 1987, this case would not be heard under the extended hearing process provided by Congress in the 1986 Medicare amendments. *See* Pub. L. No. 99-509, § 9341(a)(1), 100 Stat. 2037 (signed October 21, 1986) (amending 42 U.S.C. § 1395ff).

B. Factual Background

To promote consistency, the Secretary recently required all carriers to implement a nationally uniform system of coding medical procedures called the HCFA Common Procedure Coding System ("HCPCS"). Accordingly, in July 1985, Blue Cross began converting from its existing coding system (containing approximately 5,000 procedure codes) to the new system (containing approximately 20,000 procedure codes). Blue Cross could not accurately match all its historical "customary" and "prevailing" charge data recorded under its old system to the new system, because the old procedure descriptions did not directly correspond to the new procedure descriptions. Since Blue Cross was required to complete the conversion and begin timely processing of claims under the new codes, it placed a number of HCPCS codes on statewide fee schedules, including the 18 codes here in controversy.

Blue Cross has considerable expertise in the administration of "reasonable charge" methods. Blue Cross also had ample precedent for its choice; fee schedules frequently have been used when new procedure codes are developed and/or historical data becomes distorted—more than 6,000 are still in use. V. R. 28. Furthermore, federal law authorizes the carrier to exercise discretion in choosing a "reasonable charge" method. *See* 42 U.S.C. § 1395u(b)(3)(B) and 42 C.F.R. § 405.502(a) - (d).

Basing reasonable charges on statewide fee schedules raised some reimbursement levels. Some physicians, individually and through their trade associations, inquired about the changes and were assured by the carrier that the payment levels were correct. However, in December 1986, HCFA officials conducted a brief, two-day review of Blue Cross' procedure codes. HCFA's officials, rela-

tively inexperienced in making the matches necessary to determine "reasonable charge" methods, decided that Blue Cross' method of determining reasonable charge for 18 codes was incorrect.[2] In January 1986, the Secretary informed Blue Cross that the fee schedules had been used incorrectly for the subject procedure codes.[3] The Secretary expressly and in writing instructed Blue Cross to remove the subject procedure codes from fee schedules and to substitute reasonable charges based on the preferred method. The Secretary's instructions were not stated as a suggestion or as advice, but as a direct command, and were accompanied by a stern reprimand for having implemented the fees in the first instance. (Appendix A, pp. 37a-40a).

After receiving the Secretary's instructions, Blue Cross notified Texas physicians that the use of fee schedules for certain procedure codes was being terminated and that these codes would thenceforth be reimbursed on the basis of reconstructed "customary" and "prevailing" charge data. Blue Cross further told the physicians that it would not recoup any payments made under the fee schedules.

Sometime thereafter HCFA decided that Blue Cross' use of fee schedules was an unauthorized and illegal payment method and that the resulting reimbursements were overpayments. III R. 278. HCFA directed that Blue Cross examine all claims for services under statewide fee schedules for the 18 procedure codes and recalculate the reasonable charge using the "customary" and "prevailing"

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2. The validity of HCFA's determination was contested by Petitioners and is one of the issues which Petitioners seek to resolve in the trial on the merits.

3. The "subject procedure codes" are the 18 procedure codes at issue in this litigation, which the Secretary later decided should be subject to recoupment in the "Overpayment Project."

method. Upon discovering that the total amount involved was approximately $15 million, HCFA instructed Blue Cross to begin the Overpayment Project and to assess, as to every physician and beneficiary who filed a claim under a subject procedure code while fee schedules were in place, the difference between the amount actually paid and the recalculated amount. HCFA directed that all patients and physicians, whose accounts exceeded $50 were to be notified that overpayments had been made and must be returned. *See* "Texas Blue Shield Instructions," Appendix A, pp. 64a-68a. More than 5,000 physicians and some 15,000 Medicare beneficiaries were sent demand letters for a total of $13.5 million.

The physicians and beneficiaries were unaware of the Overpayment Project until they received the demand letters in August, 1987. The letters, which were sent to Blue Cross on "Medicare Part B" letterhead, stated that "we have now been instructed by the Health Care Financing Administration that we must recover these monies." IV R. 604. If physicians failed to make arrangements to pay the amount demanded by October 18, 1987, future Medicare payments owed to the physicians would be reduced by fifty percent until all funds claimed, plus interest, were recouped. Medicare beneficiaries were told that unless repayment arrangements were made, their monthly social security checks might be reduced.

Although the Secretary knew in late 1985 that reasonable charges had been determined based on the statewide fee method, he did not direct Blue Cross to reopen the claims and recoup the payments until August 1987. It therefore appeared that no consideration was given to the requirement that newly discovered evidence constitute the basis for reopening year-old claims. In a deposition given

in this proceeding, HCFA's regional director confirmed that appearance. (Appendix A, pp. 76a-77a).

Until the demand letters were received, no physician or beneficiary had reason to believe that the payments they had received were "illegal" and subject to recoupment. Indeed, individually and collectively, physicians were repeatedly told the contrary. Therefore, the recoupment appeared on its face to violate the requirement that no recoupments be made from persons who were "without fault" in causing the alleged overpayment. 42 U.S.C. § 1395gg(c).

C. History of Proceeding

Two days before the deadline for repayment, Petitioners, a group of physicians and Medicare beneficiaries, filed this class action against the Secretary and Blue Cross in the United States District Court for the Western District of Texas, alleging that the reopening of the claims and recoupment violated the Social Security Act, 42 U.S.C. § 1395, et seq., and the regulations thereunder. Jurisdiction was asserted under 28 U.S.C. § 1331. Petitioners sought preliminary and permanent injunctions to halt further implementation of the Overpayment Project.

At oral argument on Petitioners' motion for preliminary injunction, the Secretary's attorney represented to the court that Blue Cross had acted solely as HCFA's agent and should not be a party to the case. A motion to dismiss Blue Cross was later granted. Through his affidavits and arguments, the Secretary took the position that the government alone was responsible for all decisions involving the Overpayment Project. In his opposition to injunctive relief, the Secretary stated:

> HCFA has determined that . . . the payment methodology used by the carrier was inconsistent with the statute, regulations and instructions . . . The carrier had good cause to reopen the claims because it had been expressly directed to do so . . . HCFA had good cause to direct the carrier to reopen . . .

III R. 284-285. The regional director of HCFA testified by affidavit that HCFA "instructed" Blue Cross to take virtually every step in the process and unilaterally made all the decisions. III R. 296-299.

With such evidence before it, the district court concluded that "this dispute centers on whether the statewide fee schedule was a proper or improper payment methodology" and that the court therefore had jurisdiction under *Michigan Academy*. The court noted that 42 U.S.C. § 1395ff precludes judicial review of a carrier's determination of the amount of benefits payable in a Part B payment dispute under *United States v. Erika*, 456 U.S. 201 (1982), but that the Secretary's regulatory scheme, including the method by which amounts of benefits are determined, is not insulated from judicial review under *Michigan Academy*. The court ascertained that, under the Secretary's regulations and instructions binding a carrier hearing officer to interpret the law consistently with the Secretary's interpretation, the carrier hearing officer would be precluded from providing the physicians and beneficiaries the relief they seek. The court therefore concluded that it had jurisdiction and, upon consideration of the merits of Petitioners' motion for preliminary injunction, enjoined the Overpayment Project pending trial.

The Secretary appealed the preliminary injunction. While the appeal was pending, the Secretary filed his answer to Petitioners' original complaint, in which he

judicially admitted that Blue Cross, in conducting the Overpayment Project, was "acting on instructions issued by the Department of Health and Human Services." That answer, having been filed after the preliminary injunction was granted, was not before the court of appeals.

On June 27, 1989, the court of appeals vacated the preliminary injunction and ordered that the action be dismissed for want of jurisdiction. It is of this order that Petitioners seek this Court's review.

At the heart of the court of appeals' reasoning was its conclusion that none of the Secretary's instructions were binding instructions. The court said the instructions did not inform the carrier and its hearing officer that they were intended to be obeyed "come hell or high water." 875 F.2d at 1169. The instructions given by the Secretary to the carrier were therefore held to be reviewable by the carrier hearing officer and not by the judiciary.

The court did not explain the distinction between the Secretary's instructions in this case and "hell or high water" instructions. Nor did it explain why the Secretary's instructions in this case were not "policy statements, instructions or other guides" by which the carrier hearing officer is bound under 42 C.F.R. § 405.860. The court simply concluded that the instructions were not the sort of "regulations and instructions" that are judicially reviewable under *Michigan Academy*, but instead that all matters covered by the instructions, i.e., the legality of the use of statewide fee schedules, the existence of good cause to reopen the claims, and the existence of "fault," are "within the unfettered capacity of effective [hearing officer] review." 875 F.2d at 1170.

In reaching its conclusion, the court of appeals reviewed discovery materials that were submitted at its re-

quest. Then, based on the evidence of record and the hastily compiled, undeveloped discovery, the court concluded that the Secretary's instructions were not of a binding nature. The court of appeals did not allow any further development of evidence, but ordered that the case be dismissed for want of jurisdiction.

The court expressed considerable sympathy for Petitioners, entreating the Secretary and Blue Cross to accord fair treatment to all claimants. A few weeks later, however, instead of endeavoring to act impartially, the Secretary amended the Manual to provide that 42 U.S.C. § 1395gg (c), which prohibits recoupment from persons who are "without fault," does not apply to physicians who received overpayments as a result of incorrect reasonable charges. Manual Transmittal No. 1316 and Manual §§ 7102 and 7103.1A (July 1989). (Appendix G, pp. 137a-140a). The amendments entirely foreclose the claimants' "without fault" defense, which the court of appeals assumed was within the unfettered discretion of the hearing officer. 875 F.2d at 1170. Petitioners have filed a motion for leave to file a motion for reconsideration with the court of appeals in light of the amendments to the Manual.

REASONS FOR GRANTING THE WRIT

The decision of the court of appeals deprives Petitioners and thousands of similarly situated Medicare beneficiaries and physicians of any avenue for the redress of unjust and unlawful conduct by an officer of the United States. The decision is not only manifestly unjust and of sweeping consequence, but is contrary to this Court's decision in *Michigan Academy*, in which this Court carefully drew a line between carrier conduct in determining the amount of Medicare benefits, which is not reviewable, and the "instructions and regulations" of

the Secretary, including the method of determining the amount of benefits, which are reviewable. The decision of the court of appeals improperly moves that line to insulate the Secretary's instructions from review whenever the Secretary has made proof of those instructions difficult by conveying them privately to the carrier. This Court should grant certiorari to protect the rights of the affected claimants, to reestablish the rule it articulated in *Michigan Academy*, and to assure that informality and secrecy in governmental actions do not constitute an effective shield, protecting whatever conduct is thus taken from judicial review.

A. THE COURT OF APPEALS' DECISION TO DENY JURISDICTION CONFLICTS WITH *MICHIGAN ACADEMY*.

The jurisdictional dispute is essentially an argument over the limits of the statutory prohibition against judicial review of Medicare Part B determinations. This prohibition and its limits were explored in *Erika* and *Michigan Academy*. In *Erika*, the Court held that the conspicuous failure of 42 U.S.C. § 1395ff to authorize judicial review of amount determinations "provides persuasive evidence that Congress deliberately intended to foreclose further review of such claims." 456 U.S. at 208. In *Michigan Academy*, the Court clarified what types of claims were foreclosed.

The plaintiff physicians in *Michigan Academy* challenged a regulation, promulgated by the Secretary, which controlled the carrier's determination of the amount payable for the plaintiffs' services. The Secretary argued that, under *Erika*, judicial review of Medicare Part B matters was entirely foreclosed. This Court affirmed the lower courts' assertion of jurisdiction, however, and held

that only *amount* determinations are protected from review and that "the Secretary's instructions and regulations" are subject to challenge. 476 U.S. at 680.

As stated in *Michigan Academy, Erika* stands for the proposition that Congress intended to foreclose review of amount determinations "to avoid overloading the courts with 'trivial matters' . . . which would 'unduly tax' the federal court system." 476 U.S. at 675. A challenge to the *method* by which claims are to be determined does not present trivial matters of the sort which Congress feared would unduly tax the courts. A method of determining the amount of benefits controls the disposition of all affected claims; thus a challenge to the method does not involve "those quite minor matters" of which review is foreclosed. 476 U.S. at 680.

This case is not about trivial, individual claims. It is not about the carrier's calculation of Petitioners' payments. It is about the Secretary's actions in (1) unilaterally overruling the carrier's selection of a permissible reasonable charge method, (2) instructing the carrier to use another method, and (3) instructing the carrier to reopen and recoup all affected claims, each having a uniformly unlawful effect upon the 20,000 claimants affected.

The *Michigan Academy* Court declined to presume that Congress intended *no* forum for the review of claims involving unlawful acts by the Secretary, who had by regulation prescribed the method challenged by the plaintiffs. Since hearing officer review of the Secretary's regulations, policy statements, legal interpretations, and instructions is barred by 42 C.F.R. § 480.860 and Manual § 12016A, it followed that the physicians' challenge to the regulation was cognizable in the courts.

In cases since *Michigan Academy,* claimants seeking judicial review have, whenever possible, argued that they were challenging the method by which the amount of benefits was determined, while the Secretary has argued that all such challenges were merely artfully pleaded attacks on amount determinations. The amount/methodology distinction is not a fully satisfactory means of analyzing these claims. More recent decisions have turned instead on whether the challenged conduct was subject to effective hearing officer review, which in turn, depends upon whether the challenged conduct was initiated by the carrier or prescribed by the Secretary.

The importance of *Michigan Academy* is not merely that the courts can invalidate formally published regulations which violate the law. The importance of *Michigan Academy* is that

> [M]atters which Congress did not delegate to private carriers, such as challenges to the validity of the Secretary's instructions and regulations, are cognizable in courts of law.

476 U.S. at 680. The fact determinations pertaining to a particular payment may be reviewed by a carrier hearing officer. Regulations, like statutes, instructions, legal interpretations, policy statements, and other guides provided by the Secretary to the carrier are binding on the carrier hearing officer. 42 C.F.R. § 450.860; Manual § 12016A. The carrier may not overrule the Secretary as a matter of law nor even as a practical matter in view of the carrier's economic interest in keeping its government contract. Thus, *Erika, Michigan Academy,* and every subsequent case in which the scope of judicial review under 42 U.S.C. § 1395ff has been at issue, have turned on the determination of whose conduct was at

issue, the carrier's or the Secretary's. The courts have consistently declined jurisdiction when the challenged conduct was exclusively that of the carrier and have consistently (except for the court of appeals in this case) assumed jurisdiction when the challenged conduct was the Secretary's.

In *Kuritzky v. Blue Shield of Western New York, Inc.*, 850 F.2d 126 (2d Cir. 1988), *cert. denied*, ____U.S.____, 109 S.Ct. 787 (1989), the plaintiffs claimed that the carrier "failed to follow the provisions of both the regulations and the Manual in determining the reasonable charges to which plaintiffs are entitled." 850 F.2d at 128. Thus, they cast their complaint as a challenge to "the carrier's 'methods' in calculating benefits." *Id.* Unlike Petitioners here, the *Kuritzky* claimants did not dispute that the carrier hearing officer had authority to decide their claim, because no regulation or other instruction of the Secretary's was challenged. The court declined jurisdiction, holding that "method," as used in *Michigan Academy*, does not mean the *carrier's* method, but means the method prescribed by the *Secretary*. *Id.* "*Michigan Academy* held that a challenge to this *prescribed method* was reviewable." *Id.* (Emphasis added).

In *Association of Seat Lift Manufacturers v. Bowen*, 858 F.2d 308 (6th Cir. 1988), *cert. denied*, ____U.S. ____, 109 S.Ct. 1528 (1989), the plaintiffs again sought to overturn the *carrier's* reasonable charge determination. They asserted that the Secretary had prescribed a change in method which resulted in a reduction of payments, but the evidence clearly demonstrated the contrary. All the Secretary's communications had expressly acknowledged HCFA's lack of authority and had stated that the relevant decisions were entirely within the discretion of the carrier. Therefore, the court concluded, the Secretary

"did not 'instruct' the carrier in any way." 858 F.2d at 317. Accordingly, "only the carrier's implementation of a method, not the method itself, was at issue." *Id.* Thus, the carrier hearing officer could determine the claim. In the instant case, the admissions of counsel, the Secretary's answer, the deposition of HCFA's regional administrator, and the subsequent issuance of amendments to the Manual §§ 7102 and 7103.1A clearly demonstrate that all decisions were made by the Secretary and are beyond the scope of hearing officer review.

Similarly, in *Anderson v. Bowen,* Medicare & Medicaid Guide (CCH) ¶ 37,986 (2d Cir. July 28, 1989) (to be reported at 881 F.2d 1), the claimants asserted that they challenged an instruction given by the Secretary to the carrier, but the Secretary proved that the conduct was initiated by the carrier. The claimants showed that the Secretary had sent a letter expressing approval of the carrier's conduct and argued that the letter constituted an instruction. The Secretary, however, proved that he had sent a subsequent letter, which withdrew the first letter and expressly stated that the original letter was "not one of the items enumerated in 42 C.F.R. 405.860 which are binding on a carrier's Hearing Officer." *Anderson,* Medicare & Medicaid Guide (CCH) at 20,587. This is in marked contrast to the instant case, in which the Secretary demanded and directed all action taken by the carrier.

The same distinction, whether the challenged conduct was that of the intermediary or the Secretary, guided the court deciding a Part A case, *McCuin v. Secretary of Health and Human Services,* 817 F.2d 161 (1st Cir. 1987). 42 U.S.C. § 1395ff permits judicial review of the amount of Part A claims only where the amount of the claim is at least $1,000. A claimant whose claim was below that limit brought suit challenging a pro-

cedure which affected her benefits. After examining whether she was challenging the *amount* of benefits, of which review was precluded, or the *procedure* governing the intermediary's handling of her claim, the court concluded that *Michigan Academy* was controlling. While the claimant did not challenge a formal *regulation* promulgated by the Secretary, she showed that the Secretary's policy controlled the intermediary's determination of her claim. Concluding that the claimant challenged "the Secretary's interpretation of the regulations," the court affirmed the district court's assertion of jurisdiction. 817 F.2d at 166. (In the present case, the Secretary argued that the court should accord great deference to "the Secretary's interpretation of the Medicare regulations." II R. 285.)

In the instant case, as in *Michigan Academy* and *McCuin,* Petitioners assert a challenge to the Secretary's actions, not the carrier's. The carrier chose to establish reasonable charges based on the statewide fee method. The Secretary overrode that choice and ordered that the statewide fees be eliminated. The Secretary, not the carrier, decided to reopen and recoup all claims. In fact, the carrier urged the Secretary to desist, stating that the recoupment was "embarrassing" and "wrong." (Appendix H).

The court of appeals recognized that the Secretary initiated the Overpayment Project, but erroneously failed to conclude that the Secretary's communications were reviewable instructions. The court of appeals equivocated on the nature of the Secretary's instructions to the carrier, calling them "instructions," "directions," and "advisory instructions." The court overlooked the fact, however, that regardless of whether communications from the Secretary are described as instructions, interpretations of

law, policy statements, or "other guides," they are all equally binding on the carrier hearing officer. The hearing officer can no more invalidate a direction from the Secretary than he can a provision of the Medicare Act. 42 C.F.R. § 405.860; Manual § 12016A. As evidenced by the carrier's conduct in this case, all instructions from the Secretary are binding instructions. The court of appeals imposed an unprecedented limitation on *Michigan Academy*. Under the court of appeals' analysis, some Secretarial "instructions" prescribing the carrier's methods and procedures are reviewable, but others are not. This is error, which deprives 20,000 claimants of any meaningful redress, except as may be granted by this Court.

The court of appeals acknowledged that the instructions attached to its opinion as Appendix B "may appear to take away the carrier's discretion with respect to determining the reasonable charges," but inexplicably concluded that they "merely advise" the carrier to obey the law. 875 F.2d at 1167. Setting aside the point that they were not stated or received as advice, even such advice to obey the law as interpreted by the Secretary would bind the carrier hearing officer, who may not interpret the law "in a way different than HCFA does." Manual § 12016A.

As to the decision to reopen, the court of appeals again concluded that the hearing officer could make an independent determination, stating:

> [T]he record . . . fails to disclose any Secretary or HCFA communication instructing [Blue Cross] to reopen all claims come hell or high water, or in more austere traditional language stating that the Secretary (or authorized subordinate) had made an advance predetermination—binding on a [hearing officer]—that good cause supported the reopening of any and all individual claims.

875 F.2d at 4451. Even the limited preliminary injunction record shows, however, that the Secretary had already determined the issue of good cause and the carrier had already reopened all the claims, as it was instructed to do. The Secretary did not ask the carrier to evaluate whether there existed good cause to reopen each individual claim, as the court appeared to assume; the Secretary *directed* the reopening of all the claims and defended his action stating, "HCFA had good cause to direct the carrier to reopen the claims . . ." III R. 285. The reopening was not merely predetermined; it was a fait accompli. The Secretary obviously believed that he had unlimited authority to reopen the claims; his regional director testified (erroneously) that there is "good cause" to reopen a claim when "any kind of an error" resulted in too much being paid. (Appendix A, pp. 76a-77a).

Petitioners, like the claimant in *McCuin,* challenge the Secretary's interpretation of the law, which interpretation governed the carrier's treatment of their claims and which governs the hearing officer's review authority. 42 C.F.R. § 405.860; Manual § 12016A. To cast Petitioners' complaint as a dispute about conduct taken by the carrier in the exercise of its discretion is to ignore reality.

If there were any doubt that the Secretary had taken this matter out of the carrier's hands, that doubt was dispelled by the Secretary's promulgation of amendments to Manual §§ 7102 and 7103.1A, which were released shortly after the court of appeals overruled Petitioner's request for rehearing. Those sections now provide that the carrier may *never* find a physician to be without fault in receiving a payment based upon an incorrect reasonable charge. Having already declared the use of statewide fees to be incorrect and illegal, having unilaterally determined the existence of good cause to reopen and re-

calculate the claims, the Secretary has now foreclosed the last remaining avenue of hearing officer relief by formally establishing that the law is always on the government's side when it comes to determining fault for these so-called "overpayments."

B. THE COURT OF APPEALS USED A CONFUSED, INCONSISTENT AND ERRONEOUS STANDARD TO REVIEW THE TRIAL COURT'S PRELIMINARY FINDING OF JURISDICTION.

The court of appeals erred in reading *Michigan Academy* to demand "hell or high water" instructions from the Secretary as a prerequisite to establishing federal jurisdiction. Second, and perhaps even more fundamentally erroneous, was the court of appeals' curious view of its role in reviewing the jurisdictional determination made by the trial court on an application for preliminary injunction. The court of appeals should have either deferred to the trial court's fact-based determination that it had jurisdiction, or it should have allowed Petitioners the opportunity to engage in full discovery on the question of jurisdiction. Because it did neither, the court of appeals' decision was erroneous.

This was an interlocutory appeal from the grant of a preliminary injunction. 28 U.S.C. § 1292(a)(1). The record before the court of appeals was technically no greater than that confronting the trial court on October 29, 1987, before the parties had even commenced discovery. The trial court found a *prima facie* basis for granting jurisdiction based on: (1) the allegations of the complaint, (2) the affidavits presented by Petitioners, and (3) the affidavits and argument offered by the Secretary in opposition to the injunction.

The absence of "hell or high water" instructions from the Secretary certainly could not be divined from the record before the trial court. Petitioners plainly alleged that the actions of the carrier were taken pursuant to instructions from the Secretary and submitted already-available documents in support of this position. Because the Secretary did not deny responsibility, the question of "instructions" as opposed to "suggestions" from the Secretary did not arise in either briefing or argument to the trial court. To the contrary, the Secretary admitted that the entire action was taken on his direction.

Nevertheless, the court of appeals determined on its own that the instructions were merely advisory and therefore reversed the trial court's assertion of jurisdiction. This reversal is contrary to the well-settled principle that the non-frivolous allegations of the facts needed to support jurisdiction should be accepted if they establish a *prima facie* case for jurisdiction. *Bell v. Hood,* 327 U.S. 678 (1946). Because the question whether the Secretary had issued binding instructions was vital both to determining jurisdiction and to judging the merits, the court of appeals should have allowed the trial court to retain jurisdiction over the case and to treat any contention by the Secretary that he had not issued instructions as an attack on the merits. *Clark v. Tarrant County, Texas,* 798 F.2d 736 (5th Cir. 1986).

The court of appeals' decision is also contrary to the fundamental principle that a trial court's factual findings are not to be disturbed unless they are clearly erroneous. *Amadeo v. Zant,* 486 U.S. 214 (1988). This principle is particularly important in the preliminary injunction context, where the trial court is required to make its preliminary jurisdictional findings without the

benefit of discovery or full evidentiary development. *See Thornburgh v. American College of Obstetricians and Gynecologists,* 476 U.S. 747, 757 n.8 (1986) (trial court's determinations in preliminary injunction context warrant greater discretion where facts are yet to emerge than where facts are already established or have no controlling relevance); *United States Steel Corp. v. Fraternal Ass'n of Steelhaulers,* 431 F.2d 1046, 1048 (3rd Cir. 1970) (trial court's determinations in preliminary injunction context are given limited review given that evidentiary development is incomplete.)

Indeed, if the court of appeals doubted the correctness of the trial court's factual determination, then the proper course would have been to remand the matter for further evidentiary development, not simply to dismiss the case on the skimpy record before the court of appeals. It is well settled that if a question exists as to the court's jurisdiction, then the party bearing the burden of establishing jurisdiction should be given the opportunity to engage in discovery and gather facts supporting the jurisdictional allegations. *Majd-Pour v. Georgiana Community Hospital, Inc.,* 724 F.2d 901 (11th Cir. 1984); *Canavan v. Beneficial Finance Corp.,* 553 F.2d 860 (3rd Cir. 1977); *Budde v. Ling-Temco-Vought, Inc.,* 511 F.2d 1033 (10th Cir. 1975).

The court of appeals rejected these principles and stood the logic supporting them on its head. In essence, the court of appeals subjected the trial court's decision to a trial *de novo* despite the lack of evidentiary development. *After* the appeal had been briefed and argued, the court requested that the parties provide any post-injunction evidence they had developed on whether the Secretary's conduct in this matter constituted "instructions"

to the carrier. Petitioners had been conducting discovery, notwithstanding pendency of the interlocutory appeal, but had neither completed their depositions nor satisfied themselves that all pertinent documents had been produced.[4] The focus of evidentiary development, pending the court of appeals' review, was not on the jurisdictional issue: the trial court denied a post-injunction motion to dismiss for want of subject matter jurisdiction and the Secretary, in his Answer, *admitted* that the Overpayment Project was undertaken pursuant to instructions from the Secretary.[5] Petitioners were following an orderly course of discovery in which the jurisdictional issue would have been developed, but not as a priority matter over issues going to the substance of their case.

Out of the blue, the court of appeals decided to partially open the record, to see what it contained on the "instructions" subject, with no warning to the parties that this was to be dispositive on appeal. Having taken this glimpse at the evidence, the court decided that it "really had not" looked at these post-injunction materials —but that *if it had considered them,* nothing in these

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4. Indeed, plaintiffs' motion to compel discovery was referred to a magistrate, who chose to postpone ruling until after the court of appeals had ruled—so plaintiffs were effectively denied the ability to pursue the avenues of discovery they had already initiated.

5. The complaint alleges at IV R. 545:

> 4. Acting on instructions issued by the Department of Health and Human Services via the Health Care Financing Administration Region VI Office in Dallas, Texas, Blue Cross and Blue Shield of Texas, Inc., as the Medicare Part B carrier in Texas, has initiated a recoupment action, known as the Overpayment Project, designed to recover approximately $13,300,000.00 from Texas physicians and Medicare beneficiaries.

The Secretary's Answer, filed September 13, 1988, (not of record) states:

> 4. Defendant admits the allegations in this paragraph.

materials would have changed the court's mind on jurisdiction.

The court of appeals' position makes no sense. Either plaintiffs are entitled to have the propriety of jurisdiction based on the evidence available at the time the preliminary injunction was granted, or they are entitled to full evidentiary development, with the opportunity to address the fact-intensive standards of *Michigan Academy* with more than an *ad hoc*, partial collection of discovery materials gathered for other reasons and submitted to the court of appeals without even an opportunity to argue as to their significance. The court of appeals decision is unfair and illogical because the jurisdictional issue is in many ways a merits issue that depends on distinctions as fine as those between binding "hell or high water" instructions and "advisory instructions." It would demand preternatural foresight by a trial court on seeing the first salvos in a lawsuit to know what the documents and depositions will reveal.

At issue here is the relationship between the Secretary and a carrier regarding conduct executed by the carrier but patently initiated by the Secretary. How, at the time of filing and seeking a preliminary injunction, could Petitioners possibly have acquired the internal documentation between the Secretary and the carrier that would delineate the carrier's discretion in this conduct? How, lacking discovery, could Petitioners develop evidence on the manner in which the Secretary and carriers typically do business? This is not information that will readily be available to Medicare physicians and beneficiaries. Yet, the court of appeals' ruling would require that all plaintiffs attempting to challenge dubious conduct initiated by the government have their jurisdictional ammunition in hand

when they file or forego seeking preliminary relief. It is ironic that refusal to dismiss a complaint for lack of jurisdiction is not immediately appealable, but because a preliminary injunction was sought and granted by the trial court to prevent irreparable injury, Petitioners are held to a much higher, and probably impossible, standard for proving jurisdiction at the outset of the action.

The court of appeals' standard of review is confused because it seems to demand an advanced state of proof at the inception of a suit. This level of proof is not normally expected until after discovery and evidentiary development. It is inconsistent because it included an illicit peek at the discovery that denied Petitioners a fair chance to prepare for and address the issue. It is wrong because it runs contrary to holdings of this Court and the court of appeals itself that jurisdiction is initially to be extended based on the non-frivolous allegations of the complaint and more fully determined by reference to fully developed evidence specifically adduced on the issue. *Bell v. Hood, Clark v. Tarrant County.*

The court of appeals effectively turned this interlocutory appeal—raising a preliminary jurisdictional issue—into a plenary trial on jurisdiction, while denying the plaintiffs the usual pre-trial chance to develop their evidence or even to present the defendants' judicial admissions of crucial facts. The court of appeals may have thought that it was heeding the call of *Michigan Academy* by confronting the jurisdictional issue in this manner. Instead the court of appeals has taken the fact-based distinctions carefully carved out by *Michigan Academy* and rendered them a dead letter, merely because the Secretary did not inscribe his instructions on stone tablets. Justice requires that *certiorari* be granted and the court of appeals reversed.

CONCLUSION

For the reasons stated herein, Petitioners respectfully pray that their petition be granted and that the decision of the court of appeals be reversed and the case remanded to the district court.

Respectfully submitted,

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APPENDIX

APPENDIX A

TEXAS MEDICAL ASSOCIATION, et al.,
Plaintiffs-Appellees,

v.

Louis W. SULLIVAN, M.D.,
Secretary of Health and Human Services, et al.,
Defendants-Appellants.

No. 87-1970.

United States Court of Appeals,
Fifth Circuit.

June 27, 1989.

Physicians and beneficiaries under Medicare Part B filed suit against Secretary of Health and Human Services and carrier seeking temporary order and preliminary injunction halting further implementation of plan to recover alleged overpayments. The United States District Court for the Western District of Texas, 678 F.Supp. 643, James R. Nowlin, J., issued preliminary injunction, and Secretary appealed. The Court of Appeals, Brown, Circuit Judge, held that: (1) directions by the Health Care Financing Administration to carrier regarding the appropriate use of statewide fees for certain Medicare Part B procedures and the need to take into consideration valid customary and prevailing data for the procedures were not judicially reviewable "regulations" or "instructions," and (2) whether to reopen payments under Medicare Part B for procedures originally made in accordance with set statewide fees, which exceeded

payments caculated using previously irretrievable customary and prevailing charge data, was matter for independent determination by hearing officer, and thus was insulated from judicial review under the Social Security Act, prior to effective date of 1986 amendment.

Vacated and remanded for dismissal.

Clark, Chief Judge, concurred and filed an opinion.

Appeals from the United States District Court for the Western District of Texas.

Before CLARK, BROWN and JOLLY, Circuit Judges.

JOHN R. BROWN, Circuit Judge:

This case is an interlocutory appeal, 28 U.S.C. § 1292 (a)(1), of a preliminary injunction prohibiting Blue Cross and Blue Shield of Texas (BCBST) and the Secretary of Health and Human Services (Secretary) from recovering alleged overpayments made to doctors and patients under the Medicare (Part B) program. 42 U.S.C. §§ 1395j-1395w. Since we conclude 42 U.S.C. § 1395ff precludes judicial review, we vacate the preliminary injunction and remand to dismiss the case for lack of subject matter jurisdiction.

Patient's Medical History

BCBST is a private health insurance carrier which contracted with the Health Care Financing Administration (HCFA), a division of the United States Department of Health and Human Services, to administer the Medicare (Part B) program in Texas. As a carrier, Blue Cross determines the "reasonable charge" for services

paid for by Medicare. The "reasonable charge" constitutes the maximum amount Medicare pays for a given medical or health service. In computing the reasonable charge for a medical service, BCBST must use criteria set forth by statute, regulations and the Medicare Carriers' Manual. 42 U.S.C. § 1395u(b)(3); 42 C.F.R. § 405.501 *et seq.*; Medicare Carrier Manual (MCM) § 5000 *et seq.*, *in* 1 Medicare & Medicaid Guide (CCH) §§ 3185-3400.

In the application of these criteria, the reasonable charge for a service is generally the *lowest* of (a) physician's actual, billed charge for the service, or (b) the physician's "customary charge" for similar services determined by the physician's fee profile developed by the local Medicare carrier, and (c) the locally "prevailing charge recognized by the carrier" for similar services provided by doctors to Medicare beneficiaries. 42 U.S.C. § 1395u(b)(3). The regulations set forth in greater detail the criteria to be used in arriving at reasonable charges and allows for consideration of unspecified factors to avoid grossly deficient or excessive charges. *See generally* 42 C.F.R. §§ 405.502-.511.

In the course of determining either a physician's "customary charge" or the local "prevailing charge", BCBST originally used local numerical codes to describe medical procedures and services. These codes enable data used to establish the various charges to be computerized. However, in July 1985, BCBST was required by HCFA to switch from its local numerical codes to a national code system called the HCFA Common Procedure Coding System (HCPCS). This conversion required data for the old 4-digit codes to be transferred or cross-walked by computer to the new 5-digit HCPCS code. This complex task of cross-walking historical customary and prevail-

ing charge data—required to determine the reasonable charge for a medical procedure—to the HCPCS was further complicated by the existence of a Congressional freeze on customary and prevailing charge levels between July 1984 and January 1987.[1] Given the freeze, BCBST had to make sure that the conversion to the new HCPCS codes did not result in an inadvertent increase in the reasonable charges for the recorded medical procedures.

Symptoms

BCBST successfully converted codes and cross-walked customary and prevailing charge data for all but 18 medical procedures. BCBST had the data to convert these 18 codes, but the data was not immediately retrievable by the BCBST computer system. In response to physician complaints about underpayments for those 18 procedures, BCBST, without HCFA knowledge or approval, opted to set the fees for the 18 HCPCS codes at the highest prevailing rate in the state for each specific procedure or service. Therefore, between July 1985 and April 1986, BCBST payments for these 18 procedures did not reflect valid existing, albeit irretrievable, customary and prevailing charge data as required by HCFA in § 5020 of its Carrier Manual, and set forth by 42 U.S.C. § 1395u(b)(3) and 42 C.F.R. § 405.502. The need for valid customary and prevailing data to be reflected in the new HCPCS

1. Deficit Reduction Act of 1984, Pub.L. No. 98-369, § 2306, 42 U.S.C. § 1395u(b)(4). Congress extended until March 1, 1986, the freeze on the actual charge of nonparticipating physicians and on the "prevailing" and "customary" charge levels for Medicare reimbursement. Emergency Extension Act of 1985, Pub.L. No. 99-107, § 5(b), 99 Stat. 479, amended by Pub.L. No. 99-155, § 2(d), 99 Stat. 814 and Pub.L. No. 99-201, § 2, 99 Stat. 1665. Thus, the freeze was in effect during the time period in which the overpayment occurred.

codes is best exemplified by 42 C.F.R. § 405.507's illustrations of the application of the criteria for determining reasonable charges.[2]

HCFA learned in October-November 1985 that physician payments on certain codes exceeded the amount paid before the conversion to HCPCS codes. A December 1985 HCFA review determined that the 18 procedure codes for which BCBST was using statewide rates were the source of the overpayments. A January 22, 1986 letter from HCFA informed BCBST that the pricing of the 18 codes was incorrect and that it should reinstate valid customary and prevailing data which had been used prior to the conversion to the new codes. *See* Appendix A. It also requested BCBST to submit a plan informing HCFA of the date by which the valid customary and prevailing charge data would be loaded into

2. The following hypothetical illustration is provided by 42 C.F.R. § 405.507:

> The prevailing charge for a specific medical procedure ranges from $80 to $100 in a certain locality.
> Doctor A's bill is for $75 although he customarily charges $80 for the procedure.
> Doctor B's bill is his customary charge of $85.
> Doctor C's bill is his customary charge of $125.
> Doctor D's bill is for $100, although he customarily charges $80, and there are no special circumstances in the case.
> The reasonable charge for Doctor A would be limited to $75 since under the law the reasonable charge cannot exceed the actual charge, even if it is lower than his customary charge and below the prevailing charges for the locality.
> The reasonable charge for Doctor B would be $85, because it is his customary charge and it falls within the range of prevailing charges for that locality.
> The reasonable charge for Doctor C could not be more than $100, the top of the range of prevailing charges.
> The reasonable charge for Doctor D would be $80, because that is his customary charge. Even though his actual charge of $100 falls within the range of prevailing charges, the reasonable charge cannot exceed his customary charge in the absence of special circumstances.

the procedure codes. By April 1, 1986, the BCBST computers had matched the customary and prevailing charge data with the 18 new procedure codes. The statewide fee which BCBST had earlier "set" for the codes was replaced by reasonable charges BCBST calculated using the newly retrieved customary and prevailing charge data. BCBST did not consult HCFA[3] nor otherwise attempt to go back to using a set statewide fee for the 18 codes.[4]

Take Two Aspirin and Call Me in the Morning

HCFA was less decisive with respect to deciding whether an effort should be made to recover the overpayments to physicians and their patients (beneficiaries) under the 18 procedure codes. On the basis of BCBST's January 1987 estimate of the total overpayment, HCFA initially decided not to spend an estimated $1.8 million to rerun the computer history of the payments to determine the actual dollar amount of the overpayment.[5] Physicians consequently were led to believe no refunds would be sought.[6] A later determination that the expense

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3. The January 22, 1986 letter stated that BCBST should first "consult" before setting fees when valid customary and prevailing data was available.

4. The set statewide fees were merely a stop-gap measure enabling BCBST to keep payments up to date for the 18 codes while BCBST developed the systems capability to enable its computer to transfer or cross-walk the existing but irretrievable customary and prevailing charge data to the 18 new HCPCS procedure codes.

5. "[I]f the aggregate administrative expense of identifying and collecting a group of overpayments is more than can be reasonably expected to be collected, no action need be taken." Affidavit of Jerry D. Sconce, HCFA Regional Administrator. R. 296.

6. Medicare Newsletter No. 49 (March 1986) and Medicare Newsletter No. 226 (August 1986) informed physicians of the switch from a set fee to use of customary and prevailing charge data and stated that "adjustments and/or overpayment requests will not be recognized by the carrier."

of rerunning the computer history would be less than originally anticipated[7] and the overpayment was larger than originally estimated, resulted in HCFA asking BCBST to rerun the payment history of the approximately 440,000 claims submitted under the codes.

The results on reprocessing showed that the total potential recovery (excluding overpayments of less than $50.00[8]), totalled $13.3 million which was paid to some 5,125 physicians and almost 15,000 beneficiaries. Once the magnitude of the overpayment became apparent, HCFA directed BCBST to institute recoupment efforts.[9]

Curing the Illness But Losing the Patient?

BCBST sent letters requesting repayment of the overpayments to physicians and patients who had received Medicare funds under the 18 procedure codes. These demand letters, apparently mailed in August 1987, gave the recepients the option to pay in a lump sum or installments. Beneficiaries, but not physicians, were advised that they could apply for a waiver of liability if they were without fault in causing the overpayment and repayment would create a financial hardship. All recipients, physicians and beneficiaries, were advised of their right to contest the determination that they had been overpaid at an administrative hearing. The hearing process was fully described. Finally, if neither payment was made

7. Less than $300,000, as opposed to the original figure of $1.8 million.

8. The carrier, BCBST, recovers only those overpayments which excede $50.00. MCM § 7120.2; 2 Medicare & Medicaid Guide (CCH) ¶ 11,255.

9. The demand letters sent by BCBST to the physicians stated that BCBST had been instructed by HCFA to recover the overpayments.

nor a response given to the refund letter, all recipients were informed that the matter would be referred to HCFA or the Social Security Administration, respectively. Beneficiaries were informed that failure to pay could result in payments being taken from their Social Security checks. Physicians were informed that offsets could be made from Medicare payments due them for other services provided in the past or future.

In mid-September 1987, BCBST informed the overpaid physicians by letter (from the "Overpayment Project, Accounts Receivable Department") that they had been granted an additional 30 days in which to either pay the overpayment without interest or request a repayment schedule. Given this extension and the time span of mailing dates, no offsets against Medicare money due the provider physicians were to be made until November 2, 1987.[10]

Needless to say, the demand letters came as quite a surprise to the physicians who had previously been informed in Medicare Newsletters that no effort would be made to recover the overpayments. Even more bewildered were the patient beneficiaries who first learned of the overpayment upon receipt of repayment demand letters.

Seeking a Second Opinion

On October 16, 1987, a group of physicians and Medicare beneficiaries filed this class action against the Secretary and BCBST. The putative classes[11] sought a tem-

10. Due to complexities of the administrative process, deductions from beneficiaries' Social Security checks would be delayed well beyond November 2, 1987.

11. No classes have been certified to date. The putative classes described are "nonassigned repaid beneficiaries" "nonassigned bene-

porary order and a preliminary injunction to halt further implementation of the plan to recover the overpayments. The class request for a temporary order was denied but after briefing and extensive oral argument on October 29, 1987, the trial court granted a preliminary injunction on November 2, 1987, *Texas Medical Ass'n v. Bowen,* 678 F.Supp. 643 (W.D.Tex. 1987), from which the Secretary and BCBST now appeal.[12]

Can We Ease the Pain?

The Secretary contends that the trial court erred in granting the preliminary injunction because it lacks subject matter jurisdiction.[13] The Secretary first urges that before resorting to federal court, all administrative remedies must be exhausted. Nonetheless, even if these reme-

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ficiaries," "nonassigned physicians," and "assigned repaid physicians." For ease of reference, we will refer to the plaintiffs as either the class or TMA (Texas Medical Association), which obviously is carrying the principal burden of this litigation.

12. After the filing of this appeal, the trial court dismissed BCBST on the grounds that it was not a real party and interest. TMA has requested that BCBST be dismissed from this appeal. In response to BCBST's argument that the trial court order of dismissal is not final, TMA by letter stipulated that it waives any right to seek vacation or modification of the order. Even if we determined that BCBST's appeal is moot, we would nonetheless permit the Secretary to adopt BCBST's arguments as advanced in all briefs and at oral argument. Since the dismissal is before us and the stipulation of TMA cannot foreclose judicial consideration, we will continue to treat BCBST as a party to this appeal for no goal of judicial economy would be served by dismissal at this time, nor do we find any prejudice to TMA.

13. The Secretary and BCBST also argue that TMA has failed to satisfy the requirements set forth in *Lindsay v. City of San Antonio,* 821 F.2d 1103, 1105 (5th Cir. 1987) for issuance of a preliminary injunction. Given our resolution of the jurisdictional issues raised, we need not reach the merits of the issuance of the preliminary injunction.

dies had been exhausted, 42 U.S.C. § 1395ff precludes judicial review of the administrative determinations which would have been rendered on the issues raised in this action. Since the first argument becomes subsumed in the second, our review commences with the availability of judicial review.

In granting rights to Medicare reimbursement for medical and health care items and services,[14] Congress expressly limited judicial review of payment disputes arising under these Medicare provisions. Specifically, § 1869 of the Social Security Act (SSA), 42 U.S.C. § 1395ff,[15] provides that entitlement to benefits, eligibility to enroll for benefits and fulfillment of the requirements for enrollment are the only issues pertinent to Medicare Part B provisions entitled to judicial review. Congress opted to rely on carrier "fair hearing" officers (HOs) to provide final Part B benefit determinations in lieu of judicial

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14. 42 U.S.C. § 1395 *et seq.*

15. Prior to amendment in 1986, 42 U.S.C. § 1395ff provided in pertinent part:

> (a) The determination of whether an individual is entitled to benefits under Part A or Part B of this subchapter, and a determination of the amount of benefits under Part A of the subchapter, shall be made by the Secretary in accordance with regulations prescribed by him.
>
> (b)(1) Any individual dissatisfied with any determination under subsection (1) of this section as to—
>
> (A) whether he meets the conditions of [entitlement to benefits] or
>
> (B) whether he is eligible to enroll and has enrolled pursuant to Part B of this subchapter . . . , or
>
> (C) the amounts of benefits under Part A of this subchapter . . .
>
> shall be entitled to a hearing thereon by the Secretary to the extent as is provided in § 405(b) of this title and to judicial review of the Secretary's final decision after such hearing is provided in § 405(g) of this title.

review.[16] Only after the 1986 Amendment to § 1395ff(b)[17] were payment disputes over items and services added to § 1395ff(b)'s list of judicially reviewable Medicare Part B matters. Yet, since all of the overpayment claims at issue arose prior to the 1987 effective date of the 1986 Amendment, the statutory enlargement of judicial review under § 1395ff(b) does not apply to the instant case.

The Supreme Court first tackled the scope of judicial review under § 1395ff(b) in *United States v. Erika, Inc.*, 456 U.S. 201, 102 S.Ct. 1650, 72 L.Ed.2d 12 (1982). In *Erika* the Court held that § 1395ff precluded judicial review of a carrier's interpretation and application of the statutory and regulatory "reasonable charge" provisions in determining the "amount of benefits" payable under Part B of the Medicare program.

Later in *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 106 S.Ct. 2133, 90 L.Ed.2d 623 (1986), the Court considered the question of judicial review of a Part B regulation, and specifically a challenge as to the "method" by which amounts of benefits are to be determined. In holding that challenges to the validity of the Secretary's instructions and regulations were not insulated from judicial review under § 1395ff, the Court carefully distinguished *Michigan Academy* from *Erika*. Whereas *Erika* was a judicially unreviewable challenge to the actual determination of the *amount* to be paid, the Court found the challenge in *Michigan Academy*

16. The use of quasi-judicial hearing officers for these final benefit determinations has passed constitutional scrutiny. *Schweiker v. McClure*, 456 U.S. 188, 195-200, 102 S.Ct. 1665, 1669-1672, 72 L.Ed.2d 1, 7-11 (1982).

17. Omnibus Budget Reconciliation Act of 1986, Pub.L. 99-509, § 9313(a)(1)(B), 100 Stat. 1874, 2002-03 (1986).

subject to judicial review because it involved a challenge to the *methodology* by which amounts of benefit payments are determined. 476 U.S. at 675-78, 106 S.Ct. at 2138-40, 90 L.Ed.2d at 631-33. The *Michigan Academy* Court further explained challenges to methodology or the Secretary's instructions and regulations are not insulated from judicial review because "Congress did *not* leave [those matters] to be determined in a 'fair hearing' conducted by the carrier." *Id.* at 678, 106 S.Ct. at 2140, 90 L.Ed. 2d at 633.

A hearing officer (HO) must comply with Title 18 of the SSA and subsequently issued regulations, as well as with HCFA "policy statements, instructions and other guides" issued pursuant to contracts between the Secretary and carriers. 42 C.F.R. § 405.8670. The Medicare Carrier's Manual, a "guide" for purposes of § 405.8670, makes this clear by providing that an HO may not overrule or interpret legal provisions "in a way different than HCFA does when he disagrees with their intent." MCM § 12016 (1985). While both HOs and federal judges (be they Article I or Article III) are bound by the law and *valid* regulations, a HO cannot decide that a regulation or "instruction"/interpretation which is part and parcel of the Secretary's regulatory scheme is invalid. Such questions of validity *Michigan Academy* recognizes as the sole province of federal judges.

Given this circumscription of the HO's review powers, TMA claims that the Secretary through HCFA has retroactively and inconsistently declared a long-used payment method (the set statewide fees) illegal and has ordered BCBST to reopen and recalculate the claims under a different method, namely using the customary and prevailing data leaving open for independent decision only

the dollar amount of overpayment. According to TMA, the issue of a given payment method's legality requires a review of the Secretary's instructions, and consequently is within the district court's jurisdiction under *Michigan Academy*.

The trial court in determining it had jurisdiction to issue a preliminary injunction, grappled with the amount/methodolgy distinction and decided that at the heart of the controversy TMA was challenging the legality of a methodology (set statewide fees) for determining reasonable charges for the 18 procedure codes. 678 F.Supp. 643. The trial court focused directly on this: "[t]his dispute centers upon whether the statewide fee schedule was a proper or improper payment methodology." The trial court, however, failed to transcend the semantics of the amount/methodology distinction. It is crucial to go beyond semantics because all challenges to Part B benefit determinations can be recast as reviewable challenges to methodology since all awards of Part B benefits or payments are based on a method of calculation. To separate the grist from the chaff and method from amount, we must determine whether the challenge is to the validity of a rule, regulation, or instruction of the Secretary[18] or merely a claim that BCBST "misapplied or misinterpreted valid rules and regulations."[19] The amount/methodolgy distinction really

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18. *E.g., Linoz v. Heckler,* 800 F.2d 871 (9th Cir. 1986); *Integrated Generics, Inc. v. Bowen,* 678 F.Supp. 1004 (E.D.N.Y. 1988).

19. *Kuritzky v. Blue Shield of Western New York, Inc.,* 850 F.2d 126, 128 (2d Cir. 1988), *cert. denied,* _____U.S._____, 109 S.Ct. 787, 102 L.Ed.2d 778 (1989) (citing *Ass'n of Seat Lift Manufacturers v. Bowen,* Medicare and Medicaid Guide (CCH) § 36,110, at 13,468 (N.D. Ohio Jan. 30, 1987); *Mobile Medical Services, Inc. v. Arkansas Blue Cross and Blue Shield,* 676 F.Supp. 194 (W.D. Ark. 1987). *See generally Medical Fund-Philadelphia Geriatric Center v. Heckler,* 804 F.2d 33, 36-39 (3d Cir. 1986)).

boils down to a "distinction between the rules, regulations and statutes setting forth the proper computation method[20] and the carrier's applications of those provisions in determining the benefits owed." *Kuritzky v. Blue Shield of Western New York, Inc.*, 850 F.2d at 128 (citing *Michigan Academy*, 476 U.S. at 675-76, 106 S.Ct. at 2138-39, 90 L.Ed.2d at 631-32).

We are left to determine whether HCFA's directions to BCBST regarding the 18 new procedure codes (the transfer of valid customary and prevailing charge data and BCBST overpayments based on the set statewide fees) constitute judicially reviewable instructions or regulations of the Secretary. *Michigan Academy* and its progeny require that we assess whether an HO has the capacity to independently—free of binding regulations and determinations of the Secretary and subordinates—to hear and decide TMA's complaints deriving from BCBST's (i) replacement of set statewide fees for the 18 codes with fee profiles which reflect valid customary and prevailing charge data, and (ii) effort to recoup overpayments made to physicians and patients while set statewide fees were used since the customary and prevailing charge data could not be retrieved by BCBST's computers.

Data Transfusion: Injecting Customary and Prevailing Data

(i) Statewide Fee—"itis"

[1] TMA claims that HCFA has declared the set statewide fees BCBST initially used for the 18 procedure

20. A "method" is the Secretary's regulatory scheme for benefit payments, and challenges to that regulatory scheme are judicially reviewable because a carrier hearing officer does not have the power to countermand the Secretary's regulations.

codes illegal and instructed BCBST to cease using them. The only communication in the record between HCFA and BCBST which involves the propriety of setting statewide fees for the 18 procedure codes is the January 22, 1986 letter from the Chief of the Policy and Technical Assistance Branch of HCFA to the BCBST Medicare Division Manager. *See* Appendix A. That letter explained the purpose of HCFA's review of BCBST's fee setting process, and instructed BCBST to correct various procedure codes. Specifically, BCBST was told to "remove" the statewide set fees and to "reinstate" the valid customary and prevailing charge data which had been utilized before the conversion to the new 5-digit HCPCS codes.[21] The letter requested BCBST to submit a "corrected action plan" advising HCFA by what date valid customary and prevailing data would be reinstated. Finally, BCBST was advised that when it decided to set fees[22] in the future, if customary and prevailing data was available, BCBST should first consult with HCFA staff in the Regional Office.

The instructions[23] attached to this letter in many instances told BCBST to finish the job of converting data from the old 4-digit codes to the new 5-digit HCPCS codes. While for the most part these instructions re-

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21. As stated before, BCBST had this data but its computers were not capable of retrieving it for use in determining the reasonable charges for the 18 new procedure codes.

22. Sometimes the use of customary and prevailing data and other standard criteria prescribed by 42 C.F.R. § 405.502(a) results in too high or low a fee schedule. In such an instance, HCFA or BCBST can, with established limits, establish a "special reasonable charge limit" or set a fee in order to avoid "grossly deficient or excessive charges." 42 C.F.R. § 405.502(a)(7) and (g).

23. For the full text of these instructions, see Appendix B.

quested BCBST to "eliminate" the set statewide fees, contrary to TMA's assertions, nowhere in the correspondence (Appendix A) or specific "how to" instructions (Appendix B) was BCBST informed that the statewide fees are illegal. Instead BCBST was requested to load valid customary and prevailing data from old 4-digit codes into the new 5-digit HCPCS code. Where HCFA was uncertain about the existence of valid customary and prevailing data for an old code, it told BCBST to load or input any such existing data or alternatively to leave the set fee and make sure the Economic Index had been applied.

Read in a vacuum the Secretary's instructions may appear to take away the carrier's discretion with respect to determining the reasonable charges for various procedures. But read in the context of the relevant statutes, regulations and the BCBST contract with HCFA, these instructions merely advise BCBST to obey the law by applying available valid customary and prevailing data to the new HCPCS codes.

We cannot agree with TMA that through these HCFA advisory instructions the Secretary has declared the use of the set statewide fees illegal, and thus promulgated a new regulation or instruction which would have binding effect on any related amount determination requiring HO review. TMA mischaracterizes the HCFA direction for in the event that no valid customary and prevailing charge data was available, the set statewide fees were to be retained. Also, until the valid customary and prevailing data was matched to a relevant procedure code, no one could know whether a skewed ("grossly deficient or excessive") figure would result thus enabling BCBST to set a fee pursuant to 42 C.F.R. § 405.502(a)(7) and (g).

In this instance, HCFA is clearly acting within its oversight role. In its general oversight role HCFA "assur[es] that Carriers apply pertinent statutes, regulations, and instructions in making such [reasonable charge] determinations, and br[ings] pertinent information to the Carrier's attention for use in carrying out these responsibilities." *Ass'n of Seat Lift Manufacturers v. Bowen*, 858 F.2d 308, 315 (6th Cir. 1988). In this instance HCFA was monitoring BCBST's conversion to the new 5-digit "national" HCPCS codes. HCFA audited BCBST and determined that the conversion process had not been properly completed—specifically, due to the limitations of BCBST's computer system capability, valid customary and prevailing data could not be cross-walked to the 18 new HCPCS codes. BCBST decided to handle this problem by setting a statewide fee for the 18 procedure codes —a decision which HCFA in carrying out its oversight responsibility informed BCBST was contrary to the proper implementation of the conversion from old to new codes.[24]

Our review of the record convinces us that the HCFA directions regarding the appropriate use of set statewide

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24. We find it significant that HCFA limited its directions and advice to a discussion of proper handling of the conversion project and the generalities of setting fees. HCFA did not purport to determine reasonable charges for the carrier, nor did HCFA tell BCBST that after properly cross-walking or loading the valid customary and prevailing data that it could not opt to set a statewide fee for a given procedure code. (BCBST was told to first consult HCFA which we interpret to be no more than a cautionary statement to the effect that "you must obey the law.") Thus, as in *Seat Lift Manufacturers*, the correspondence from HCFA to the carrier did not instruct the carrier how to derive the allowable reasonable charge for a particular item or service. Although the letters in the instant case may give stronger advice than the memoranda in *Seat Lift Manufacturers*, this stronger advice was directed toward implementation of the coding system and had only incidental impact on reasonable charge determinations.

fees and the need to take into consideration valid customary and prevailing data for the 18 new procedure codes are not regulations or "instructions" which would bind a HO to find the use of the set statewide fee to compute the disputed payments to the physicians and patients were *per se* illegal, and therefore possibly not subject to judicial review under 42 U.S.C. § 1395ff.

(ii) The Rx: Decision to Reopen

[2] We now move to the question of whether HOs could make an independent determination on a claim-by-claim basis of the merits of the decision to reopen the payments for the 18 procedure codes originally made in accordance with the set statewide fees. The record shows that after considering the newly loaded valid customary and prevailing charge data, BCBST dropped the set statewide fees. Since the previously set statewide fees exceeded the payments calculated using the previously irretrievable customary and prevailing charge data, BCBST was faced with a large overpayment which had been made to physicians and patients from approximately July 1985 to March 1986. In August 1987, more than a year after BCBST stopped using the set statewide fees for the 18 procedure codes, BCBST sent letters to physicians and beneficiaries seeking recoupment of the overpayment. The letters to the physicians stated that HCFA had instructed Blue Cross to recover the overpayments made for the 18 procedure codes.

Under the TMA theory that correspondence between HCFA and BCBST concerning the decision to reopen the payment determinations constitutes binding "instructions" from the Secretary and thus are judicially reviewable because they stand outside the purview of meaningful

HO review, we culled the record for the text of these instructions. Finding only letters describing the project to determine whether recoupment should be sought, we requested counsel to submit any and all letters and correspondence from "the Secretary or HCFA which instruct Blue Cross to reopen the claims, proceed with collection refunds, etc." Letter to Counsel of Record, Jan. 30, 1989.[25] Since this case is ongoing in district court and developments there consistent with this opinion might be decisive, we were looking for communications which by their terms would constrain a putative HO from determining that the Secretary or HCFA had ruled on the

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25. Our request was based on TMA's representation at oral argument that such documents had subsequently been produced in the course of the on-going litigation of the permanent injunction. For a summary of the correspondence and letters submitted, see n. 29, *infra*. In our letter to counsel we reserved judgment on whether documents not specifically a part of the record of the preliminary injunction case but a part of the record in the district court may be used in this court's review of the preliminary injunction. Although our request for supplemental documents may seem odd, at best, we concluded that jurisdiction, like a F.R.Civ.P. 12(b)(6) motion is a matter in which potential evidence, even if ultimately inadmissible at trial, can be considered for purposes of disposing of the issue at hand. *See* 2A *Moore's Federal Practice*, ¶ 12-09[3]. The burden before the trial court was on TMA as plaintiff to sustain its contention that the HO would be disqualified because the HO was under binding instructions from the Secretary or HCFA that would bar review by the HO. Only by making good on this contention would the district court have jurisdiction of the case. If the record is insufficient to support jurisdiction as such, then the district court erred. In this instance, TMA was effectively given a second chance to furnish documents constituting binding Secretary of HCFA instructions to reopen which would support jurisdiction. (Since we are not umpiring a baseball game, we need not wait for a third strike before calling TMA "out.") The Secretary did not object to our request, but responded that no documents—including those submitted by TMA—existed to establish TMA's contention. Since our thorough review of those documents leads us to agree with the Secretary that TMA's suppplemental documentation fails to sustain jurisdiction, in effect we have simply not used non-record material.

merits of any such reopening. This would include the question of whether the reopening was timely since initial payment determinations can only be reopened 12-48 months later if "good cause" exists for the reopening. 42 C.F.R. § 405.841(b).[26] Three events give rise to a finding of good cause: (i) discovery of new and material evidence not considered in the initial determination,[27] (ii) clerical error, or (iii) "an error on the face of the evidence on which such determination or decision is based." 20 C.F.R. § 404.958, MCM § 121007.

The trial court in determining the 4th criteria of TMA's likelihood of prevailing on the merits[28] held that the Secretary and BCBST had not established any of the three criteria for a good cause for reopening. 678 F.Supp. at 648-49. The very analysis of the trial court exemplifies the intrusion by a federal court into the process of exclusive determination by a HO, free of binding contrary instructions, of the issue of timeliness and good cause. Nothing in the trial court's detailed analysis discusses or describes an "instruction" of HCFA or the Secretary which would command a HO to reject a claim or defense by a physician or patient that BCBST lacked good cause

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26. Section 405.841 provides in pertinent part:

> An initial . . . determination of a carrier . . . may be reopened by such carrier . . .
>
> . . . .
>
> (b) After such 12-month period [from the determination], but within 4 years from the date of notice of the initial determination to the party of such determination, upon establishment of good cause for reopening such determination. . . .

27. For the definition of new and material evidence, see MCM § 12100.8A.

28. This determination was made during the court's analysis of whether TMA had established the first of the four prerequisites to the grant of preliminary injunction. *Canal Authority of Florida v. Callaway,* 489 F.2d 567, 572 (5th Cir. 1974). *See also* n. 13, *supra.*

to reopen the payment determinations. Our thorough review of the record and the supplementary documents provided by counsel[29] also fails to disclose any Secretary

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29. The numerous documents in the official record on appeal from the preliminary injunction related primarily to the HCFA decisions as to whether it would be economically feasible to collect the overpayment and liaison with BCBST in terms of evaluating the feasibility of recoupment. These documents do not relate to an instruction or order to reopen the claims.

TMA's supplemental documentation falls into 3 groups:

(i) written communications from HCFA to BCBST; (ii) HCFA internal memoranda summarizing and referring to meetings and directions given to BCBST plus excerpts of the deposition of J.D. Sconce, Regional Administrator of HCFA; and (iii) material (a deposition and letter) which confirm that HCFA directed BCBST to initiate the recoupment of overpayments. TMA's Index of Supplemental Documents Provided to the Court is reproduced in Appendix C. (Documents marked with an asterisk [*] were already part of the Record on Appeal.) These documents are included in the Appendix E, not published but filed with this opinion.

Documents in Group (i) focus on the identification and collection of overpayments and offset procedures for overpayments which were not voluntarily refunded. The 10/5/87 letter from Regional Director Sconce to BCBST expressly states that it constitutes " 'one time only' " instructions" applicable to recoupment efforts directed to beneficiaries. These instructions are confined to "equitable waiver determinations" in instances where beneficiaries request waiver of repayment of $200 or less. Finally, in Group (i) are two sets of "Texas Blue Shield Instruction" which cover the "Processing the Beneficiary-Recovery Reasonable Charge Reduction Overpayments." TMA concedes that it is unclear when these instructions were sent to BCBST. Nonetheless, the absence of any mention of the propriety of the reopening of the payments indicates that these instructions assume that no obstacle impedes the reopening of the claims.

Viewing Group (i) as a whole, no statement is made by any HCFA official that "good cause" as used in 42 C.F.R. § 405.841(b) (*see* n. 26, *supra*) supports the reopening of the claims nor is any reference made to "good cause" as a possible factor or defense. Similarly, Groups (ii) and (iii) also lack any hint that HCFA has made a finding of "good cause" which would compel a HO to hold that the Secretary through a subordinate had issued a binding interpretations or instructions that "good cause" existed so that the reopening of each and every claim made under the 18 procedure codes from July 1985 to March 1986 was proper. What the documents do show is that HCFA, in its oversight role, told BCBST to initiate the Over-

or HCFA communication instructing BCBST to reopen all claims come hell or high water, or in more austere traditional language stating that the Secretary (or authorized subordinate) had made an advance predetermination—binding on a HO—that good cause supported the belated reopening of any and all individual claims. Absolutely nothing in the record or supplementary documentation furnished by counsel shows that the Secretary made any interpretation of the regulations or imposed any binding instruction either supporting the existence of "good cause" to reopen the collective or individual claims of the physicians and patients or deciding any other factor on the merits.

We conclude that whether good cause existed is a matter for independent determination by the HO, and thus is a matter insulated by 42 U.S.C. § 1395ff from judicial review as so plainly declared in *Michigan Academy* and its progeny.

Since the court was without jurisdiction, the trial court erred in granting a preliminary injunction. We must vacate the preliminary injunction and remand to dismiss the case.

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payment/Recoupment Project and played a supervisory role in the recoupment effort. Although HCFA assisted BCBST with the processing of overpayment claims, it was merely acting in its oversight role and never established or even remotely declared any policies or rules which would be binding on a HO called upon to determine the merits of reopening or deciding any of the individual payment claims.

Although the Secretary provided no additional documentation, BCBST submitted 2 supplemental documents (see Appendix D for identification) pursuant to our request. (These materials are identified in Appendix D and included in unpublished Appendix E.) These documents both related to the change in fees resulting from the use of valid customary and prevailing data for various codes. Neither document sheds new light on the decision to reopen or what the decision on reopening would be.

Outpatient Care

We have determined that § 1395ff precludes federal court review of these challenges to the reopening and calculation of payments under the 18 procedure codes. This means that since we find these challenges are matters which are proper for and within the unfettered capacity of effective HO review, the physicians and beneficiaries have failed on the additional and now superfluous ground of failure to exhaust the administrative remedies before seeking relief from a federal district court.[30]

David Need Not Slay Goliath

[3] We are cognizant, however, that TMA makes persuasive argument that the sheer size and magnitude of the potential claims by physicians and beneficiaries distinguishes this case from routine carrier amount determination by a HO. While this factor does not, as urged by TMA, either permit or lead us to permit judicial review under § 1395ff and *Michigan Academy*, we do emphasize the need for a system to be devised to expedite and consolidate these HO hearings in the reopened claims. We voice the serious hope that a system can be devised with the full collaboration of the Secretary, HCFA and the interested beneficiaries and physicians for (i) a composite type hearing and determination with respect to the nearly universal common issues with a workable

30. The district court held that the physicians and beneficiaries need not exhaust their administrative remedies because an HO would be barred by 42 C.F.R. § 405.860 from countermanding the so-called instructions of the Secretary. As stated in detail, we find this matter wholly within the realm of permissible, effective HO review. Also we find no pigeon hole for this matter within the four exceptions to the doctrine of exhaustion enunciated in *Patsy v. Florida Int'l University*, 634 F.2d 900, 903-04 (5th Cir. 1981), *rev'd on other grounds*, 457 U.S. 496, 102 S.Ct. 2557, 73 L.Ed.2d 172 (1982).

subsequent administrative determination of dollars, if any, due from each respondent, (ii) allowing issues (other than dollar amounts) peculiar to each physician and beneficiary to be severed for individual action on the basis of the controlling determinations made in (i). *See Pollgreen v. Morris,* 770 F.2d 1536, 1546 (11th Cir. 1985). Although the prospect seems staggering, the experience of busy federal trial courts in today's mass tort and class action cases demonstrates that the challenge can be met by innovative, imaginative collaboration of all interested parties. Such a system would assuredly serve the public interest.

A Shot for the Doctors

Finally, we also see it fit to assuage the fears of the physicians by assuring them that the six-month time limit which 42 C.F.R. § 405.821(d) places on a party's right to request a hearing is effectively tolled by the filing of the complaint in the district court on October 16, 1987. Given § 405.821's provision that, "[t]he carrier may, upon request by the party affected, extend the period for filing the request for hearing," we urge BCBST, HCFA and counsel representing the physician and beneficiary classes to adopt a uniform deadline of filing hearing requests affording the parties a minimum of 122 days[31] for filing. This 122-day minimum period would commence once this opinion and our judgment becomes final and subject to no further usual review.

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31. We derive this magic number from the following formula. The six-month period starting August 31, 1987 (the last possible day of initial letter mailing to physicians and beneficiaries) consists of 170 calendar days. Forty-eight of those days elapsed before the complaint was filed (October 18, 1987) leaving 122 days for hearing requests to be filed.

We cannot overemphasize the bald faith we are placing, albeit necessarily so, in the Secretary, HCFA and BCBST to prescribe a workable system that will ensure that the magnitude of the potential claims to be reviewed in the requisite hearing process for all claims of $100 or more[32] and not impede the fundamental fairness due to all physicians and beneficiaries entitled to such review.

The judgment must be vacated and the case remanded for want of jurisdiction.

VACATED AND REMANDED FOR DISMISSAL.

32. 42 C.F.R. § 405.801(a).

APPENDIX A

January 22, 1986

Our Reference: DPO-R6-3:MF
CP-COD-TBS

Ms. Lelia Wright

Medicare Division Manager

Blue Cross-Blue Shield of Texas

Post Office Box 660156

Dallas, Texas 75266-0156

Dear Lelia:

On December 17 and 18, 1985, staff from the Division Program Operations conducted a special review of Texas Blue Shield's fee setting process. The review was scheduled as a result of several indications to us that the carrier had set fees for procedure codes when valid customary and prevailing data were available. The purpose of the review was twofold; one, to review the fee setting process in general, and second, to review codes which we had identified as those where fees may have been set incorrectly.

As a result of our review, we are requesting that the carrier immediately initiate action to correct the pricing on the codes identified in Attachment 1. Please submit to us a corrective action plan telling us by what date the carrier expects to remove the fees and reinstate the valid customary and prevailing data.

We are disappointed with the performance of Texas Blue Shield in this area. While we understand that the conversion process was difficult and that there would be a

number of areas which would require clean up, we did not anticipate the carrier taking actions which would result in unprecedented increases in Medicare allowables.

When setting fees in the future, if there are valid customary and prevailing data available, do not set a fee without prior consultation with staff in the Regional Office. Also, the carrier should maintain documentation on all fees which are set. This documentation should indicate the reason the fee was set, e.g., no data available; how the EI was applied if pertinent; source of the pricing; and any other material which would be relevant.

When the carrier prices services during the HCPCS update, it should be careful in assigning prices if multiple codes are being translated to a single new code. In addition to looking at RVU's, the carrier should take into account frequency and other factors, i.e., what is the effect of the pricing.

If you have any questions, call Magda Flores at 767-6441.

Sincerely,

Lanny S. Day, Chief
Policy and Technical
Assistance Branch

bcc:

Steve McAdoo, Onsite Specialist

Jim Reed, DFO

Carl Silvernail, SCOB

Official and Reading Files

DPO/MFlores/mf/—D1/15

APPENDIX B

ATTACHMENT 1 TO APPENDIX A

Procedure Codes Which Require Action

1. 90060—Eliminate fee. Load Valid customary and prevailing data from 1-9005 into this code.
2. 90250—Eliminate fee. Load Valid customary and prevailing data from 1-9025 into this code.
3. 66983—Eliminate fee. Load Valid customary and prevailing data from 2-5620 into this code.
4. 66984—Eliminate fee. Load Valid customary and prevailing data from 2-5622 into this code.
5. A0220—Eliminate fee. Load Valid customary and prevailing data from 9-6012 into this code.
6. A0223—Eliminate fee. Load Valid customary and prevailing data from 9-6013 into this code.
7. 67908—Eliminate fee. Load Valid customary and prevailing data from 2-5727 into this code.
8. R0070—Eliminate fee. Load Valid customary and prevailing data from 4-7468 into this code.
9. R0075—Eliminate fee. Load Valid customary and prevailing data, if available, in this code.
10. W7451—Eliminate fee. Load Valid customary and prevailing data from 4-7451 into this code.
11. W7453—Eliminate fee. Load Valid customary and prevailing data from 4-7453 into this code.
12. W7460—Eliminate fee. Load Valid customary and prevailing data from 4-7460 into this code.

13. 74000—Eliminate fee. Load Valid customary and prevailing data from 4-7350 into this code.

14. 67143—Eliminate fee. Load Valid customary and prevailing data from 2-5635 into this code.

15. Z9072—Eliminate fee. Load Valid customary and prevailing data from 1-9072 into this code.

16. 51595—Leave on fee. Ensure that the Economic Index has been applied to this procedure.

17. 33460—Determine if the code this converted from profiled in FSY86. If so, compare current fee to this and bring back into line if it is different.

18. 90784—If there were valid customary and prevailing data in the 1-9084, this data should replace the fee. If not, leave the fee and ensure that the EI has been applied.

19. 90798—See above recommendation.

20. 52320—Ensure that the EI has been applied.

21. 95860 to 95864—Leave as is.

22. M0702 to M0710—Ensure that the EI has been applied.

23. 78202—Ensure that the EI has been appplied. Otherwise, leave as is.

24. L6250—Leave as is.

25. L6710—Leave as is.

26. 67216—Ensure application of EI. Otherwise, leave as is.

27. 67226—Ensure application of EI. Otherwise, leave as is.

28. 67104—Ensure application of EI. Otherwise, leave as is.

29. 67106—Ensure application of EI. Otherwise, leave as is.

30. 67146—Ensure application of EI. Otherwise, leave as is.

31. 93309 & 76629—Ensure application of EI. Otherwise, leave as is.

32. 99171 to 99174—Compare to RVU × PCF pricing. If it's in line, leave as is. Otherwise, make necessary adjustments.

33. 90640 to 90643—Load the prevailing fee of the appropriate office visit code in each locality and speciality. Leave customaries to default pricing (50th percentile). If this is not feasible, array the prevailing charges for the office visit codes and select the 75th percentile.

APPENDIX C[1]

Index of Supplemental Documents

Provided by TMA[2]

I. Written communications from the Health Care Financing Administration ("HCFA") to Blue Cross and Blue Shield of Texas, Inc. ("Blue Cross"):

A.* Letter of January 22, 1986, from Lanny S. Day, Chief, Policy and Technical Assistance Branch, HCFA, to Lelia Wright, Medicare Division Manager, Blue Cross, requesting immediate prospective changes in pricing, with attachment:

1. "Procedure Codes Which Require Action", stating in detail the prospective pricing changes required by HCFA.

B. Correspondence between Blue Cross and HCFA in which Blue Cross requested and HCFA granted permission to delay the Overpayment Project until after "BMAD specifications" became available and referring to budgeting for the Overpayment Project:

1. Letter of March 9, 1987, from Barbara Harvey, Director, Staff Services, Blue Cross, to Magda Flores, Division of Program Operations, HCFA;

2. Letter of March 19, 1987, from Lanny S. Day to Lelia Wright.

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1. These documents have been filed with the Clerk as an unpublished Appendix E.

2. Items marked with an asterisk (*) are in the official record of the preliminary injunction.

C. Letter of July 23, 1987, from Lanny S. Day to Lelia Wright forwarding HCFA-approved letters to be sent by Blue Cross to beneficiaries and physicians:

1. HCFA-approved letter to be sent by Blue Cross to physicians where claims were assigned and where there were no beneficiary co-payment obligations.

2. HCFA-revised and approved letter to be sent by Blue Cross to beneficiaries where claims were unassigned.

3. HCFA-approved letter to be sent by Blue Cross to physicians where claims were assigned and where the beneficiary had co-payment obligations, and

4. HCFA-approved letter to be sent by Blue Cross to beneficiaries where claims were assigned but where beneficiary had co-payment obligations.

D. Letter of August 28, 1987, from J.D. Sconce, Regional Administrator, HCFA, confirming recoupment procedures and enclosing to Lelia Wright:

1. Language to be included in recoupment letters to physicians.

E. Letter dated October 5, 1987, from B.E. McCutcheon, Associate Regional Administrator, HCFA, signing for J.D. Sconce to Lelia Wright, providing instructions pertaining to recovery from beneficiaries and enclosing:

1. A form letter which Blue Cross was instructed to complete for forwarding to beneficiaries in certain cases.

F. "Texas Blue Shield Instructions." (This document was produced by Secretary Bowen in discovery. It is unclear when these instructions were transmitted to Blue Cross. It appears that they were developed by HCFA's Central Office and forwarded to Dallas. See II.C. below.)

G. "Texas Blue Shield Instructions." (This document is similar, but not identical to the document described in I.F., above. See II.D., below.)

II. Internal HCFA documents referring to HCFA's instructions to Blue Cross.

A. Memorandum of May 7, 1987, from Magda Flores to Lanny S. Day, discussing her meeting with Blue Cross personnel.

B. Memorandum of August 28, 1987, from Magda Flores regarding her meeting with Blue Cross and HCFA personnel of the same date and referring to her delivery of HCFA's letter identified as I.D., above.

C. Memorandum of October 14, 1987, from Thomas Castello, Chief, Beneficiary Debt Management Branch, HCFA Central Office, to HCFA's Associate Regional Administrator in Dallas, enclosing "Texas Blue Cross Instructions." (Enclosure provided at I.F., above.)

D. Memorandum of October 21, 1987, from Samuel N. Guida, Director, Division of Overpay-

ment Prevention, HCFA Central Office, to HCFA's Associate Regional Administrator in Dallas, enclosing "final instructions," i.e., "Texas Blue Shield Instructions." (Enclosure provided at I.G., above.)

E. Excerpt of Plaintiffs' deposition of J.D. Sconce, Regional Administrator, HCFA, February 18, 1988.

F. Document prepared by Mr. Sconce's staff to explain the Overpayment Project (described in Mr. Sconce's deposition).

III. Confirming material from Blue Cross.

A. Excerpt of Plaintiffs' deposition of Rogers K. Coleman, M.D., Vice President, Medical Director, Blue Cross, February 19, 1988.

B.* Letter of August 14, 1987, from Dr. Coleman to Louis J. Goodman, Ph.D., describing HCFA's instructions to Blue Cross.

APPENDIX D[1]

Supplemental Documents Submitted by BCBST

1. March 10, 1986 Letter from Lelia Wright, Division Manager, Medicare, BCBST, to Lanny Day, Chief, Policy and Technical Assistance Branch, HCFA. Describes BCBST's review of pricing problems described in Day's January 22, 1986 letter to BCBST. (Appendix A).

2. March 31, 1986 reply of Day to Wright's letter of March 10, 1986. Day asks to review "the profile build and related data" for two procedure codes.

CLARK, Chief Judge, concurring.

When the Secretary determined that an unauthorized method of calculating payments had been followed, he required the payments to be redetermined by the previously provided method. Although the requirement covered many claims involving a large total number of persons and money, each separate matter related solely to the amount of benefits to be paid on a pre-1987 Part B Medicare claim. On this basis, I concur in the majority's holding that both *Erika* and *Michigan Academy* bar judicial review of the Secretary's requirement and the payment recoupment proceeding.

Because the district court and this court are without jurisdiction, we are also without power or right to comment on the methods or procedures to be followed by the Secretary in the future handling of these claims. I respectfully dissent from the final three labeled portions of the majority opinion.

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1. These documents have been filed with the Clerk as an unpublished Appendix E.

[NOTE: The following Appendix E to the Opinion of the Fifth Circuit Court of Appeals consists in the original of various evidentiary materials, which contain handwritten notes, deletions, and other marks that have been difficult to reproduce. A photocopy of the original has been lodged with the Clerk of this Court.]

No. 87-1970

Texas Medical Association, et al.

v.

Otis R. Bowen, Etc., et al.
Blue Cross And Blue Shield of Texas, Inc.

Before Clark, Brown, and Jolly, Circuit Judges.

APPENDIX E

(Not Published)

Supplemental Documents
Provided by TMA and BCBST
Pursuant to this Court's Request*

* *See* nn. 25 and 29, *supra*.

I. Documents Furnished by TMA

I.A.

January 22, 1986

Our Reference: DPO-R6-3:MF
CP-COD-TBS

Ms. Lelia Wright
Medicare Division Manager
Blue Cross-Blue Shield of Texas
Post Office Box 660156
Dallas, Texas 75266-0156

Dear Lelia:

On December 17 and 18, 1985, staff from the Division of Program Operations conducted a special review of Texas Blue Shield's fee setting process. The review was scheduled as a result of several indications to us that the carrier had set fees for procedure codes when valid customary and prevailing data were available. The purpose of the review was twofold: one, to review the fee setting process in general, and second, to review codes which we had identified as those where fees may have been set incorrectly.

As a result of our review, we are requesting that the carrier immediately initiate action to correct the pricing on the codes identified in Attachment 1. Please submit to us a corrective action plan telling us by what date the carrier expects to remove the fees and reinstate the valid customary and prevailing data.

We are disappointed with the performance of Texas Blue Shield in this area. While we understand that the conversion process was difficult and that there would be a number of areas which would require clean up, we did

not anticipate the carrier taking actions which would result in unprecedented increases in Medicare allowables.

When setting fees in the future, if there are valid customary and prevailing data available, do not set a fee without prior consultation with staff in the Regional Office. Also, the carrier should maintain documentation on all fees which are set. This documentation should indicate the reason the fee was set, e.g., no data available; how the EI was applied if pertinent; source of the pricing; and any other material which would be relevant.

When the carrier prices services during the HCPCS update, it should be careful in assigning prices if multiple codes are being translated to a single new code. In addition to looking at RVUs, the carrier should take into account frequency and other factors, i.e., what is the effect of the pricing.

If you have any questions, call Magda Flores at 767-6441.

Sincerely,

Lanny S. Day, Chief
Policy and Technical
Assistance Branch

bcc:

Steve McAdoo, Onsite Specialist
Jim Reed, DFO
Carl Silvernail, SCOB
Official and Reading Files
DPO/MFlores/mf—D1/15

Procedure Codes Which Require Action

1. 90060 — Eliminate fee. Load valid customary and prevailing data from 1-9005 into this code.

2. 90250 — Eliminate fee. Load valid customary and prevailing data from 1-9025 into this code.

3. 66983 — Eliminate fee. Load valid customary and prevailing data from 2-5620 into this code.

4. 66984 — Eliminate fee. Load valid customary and prevailing data from 2-5622 into this code.

5. A0220 — Eliminate fee. Load valid customary and prevailing data from 9-6012 into this code.

6. A0223 — Eliminate fee. Load valid customary and prevailing data from 9-6013 into this code.

7. 67908 — Eliminate fee. Load valid customary and prevailing data from 2-5727 into this code.

8. R0070 — Eliminate fee. Load valid customary and prevailing data from 4-7468 into this code.

9. R0075 — Eliminate fee. Load valid customary and prevailing data, if available, into this code.

10. W7451 — Eliminate fee. Load valid customary and prevailing data from 4-7451 into this code.

11. W7453 — Eliminate fee. Load valid customary and prevailing data from 4-7453 into this code.

12. W7460 — Eliminate fee. Load valid customary and prevailing data from 4-7460 into this code.

13. 74000 — Eliminate fee. Load valid customary and prevailing data from 4-7350 into this code.

14. 67143 — Eliminate fee. Load valid customary and prevailing data from 2-5635 into this code.

15. Z9072 — Eliminate fee. Load valid customary and prevailing data from 1-9072 into this code.

16. 51595 — Leave on fee. Ensure that the Economic Index has been applied to this procedure.

17. 33460 — Determine if the code this converted from profiled in FSY86. If so, compare current fee to this and bring back into line if it is different.

18. 90784 — If there were valid customary and prevailing data in the 1-9084, this data should replace the fee. If not, leave the fee and ensure that the EI has been applied.

19. 90798 — See above recommendation.

20. 52320 — Ensure that the EI has been applied. Otherwise, leave as is.

21. 95860 to 95864 — Leave as is.

22. M0702 to M0710 — Ensure that the EI has been applied. Otherwise, leave as is.

23. 78202 — Ensure that the EI has been applied. Otherwise, leave as is.

24. L6250 — Leave as is.

25. L6710 — Leave as is.

26. 67216 — Ensure application of EI. Otherwise, leave as is.

27. 67226 — Ensure application of EI. Otherwise, leave as is.

28. 67104 — Ensure application of EI. Otherwise, leave as is.

29. 67106 — Ensure application of EI. Otherwise, leave as is.

30. 67146 — Ensure application of EI. Otherwise, leave as is.

I.B.

MEDICARE PART B
Group Medical & Surgical Service
P.O. Box 222147, Dallas, Texas 75222

March 9, 1987

Ms. Magda Flores
Health Care Financing Administration
1200 Main Tower Building
Dallas, Texas 75202

Dear Ms. Flores:

When my staff and I met with you and Julie Milan a few weeks ago regarding the potential overpayment that exists, you requested that I obtain some additional information. This information includes our cost and time estimates for completing this project. As you are aware, this will be a very costly and labor intensive project. It is also difficult to estimate much of the clerical time that will be involved as a result of telephone and written inquiries as well as the congressional interest that will probably occur as a result of this project.

We are proposing that we use BMAD data rather than pulling this data from history. We have the BMAD data for calendar year 1985 which would include any overpayments made between 7-1-85 and 12-31-85. We planned to extract the remaining data from the 1986 BMAD files. This would include any overpayments made for physician services from January 1, 1986 through March 31, 1986 and ambulance services from January 1, 1986 through August 31, 1986. Our assumption that BMAD data could be used for claims paid in 1986 was based on our receiving instructions for the 1986 BMAD data pull by March 1, 1987. We have not received these instructions and have been informed by the HCFA Central Office that this date may slip considerably. Our cost and time

projections were based on using this data. There will be an increased cost if we are required to pull this data from history.

The following projections are based on the assumption that we can use BMAD data even though we will be delayed by the delay in the BMAD instructions for 1986.

PHASE I — Extract incorrectly paid procedures, reprice, and print preliminary overpayment reports.

1) Programming	$28,800.
2) Computer time	46,500.
3) Print Cost	21,103.
Total Phase I Cost	$96,403.

PHASE II — Print letters and reports for mailing, set up recoupments and work overpayments.

1) Programming	$ 8,400.
2) Print Cost	21,103.
*3) Clerical Cost	1,673,404.
4) Postage and Mailing	74,957.
Total Phase II Cost	$1,777,864.

* This represents the time of 30 full time personnel for 152 weeks using our standard of 7.8 claims/hour. This is based on the assumption that we would be required to recoup monies for all 1,333,253 claims. This also includes the ambulance claims. When Phase I of this project is completed, we will then be able to better estimate our clerical cost. However, it should be noted that the other large overpayment project did take 8 people 18 months to complete this project and only involved assigned claims and 2,900 providers.

If you cannot agree to our waiting to use the 1986 BMAD data, there will be an additional $40,200 in computer costs related to Phase I of this project.

These projections were based on estimated data using counts from the 1985 BMAD file projected through March 31, 1986.

Estimated Total Details	1,578,459
Estimated Total Claims	1,333,253
Estimated Non-assigned Claims	513,933
Estimated Beneficiaries	321,207
Estimated Assigned Claims	819,320
Estimated Performing Providers	19,508

Average: 1.6 claims per beneficiary
42 claims per provider

You had also asked that we attempt to project what percent of the overpayment would actually be recouped. Based on our experience with one other large overpayment project, we found that 52 percent of the providers with overpayments of less than $50 and 4 percent of the monies in the overpayment amounts were less than $50. Our records show that of the remaining monies, 89 percent was recouped. The actual amount of the recoupment was $1,149,584 and the cost of completing the project was $357,433.

In summary, in order to determine exactly how much money is involved, it will be necessary to run Phase I of this project and will involve spending the $96,403. Once this has been run and we review the data, we can more accurately determine the cost involved in Phase II.

We would appreciate your response as soon as possible regarding the funding and whether we can wait to use BMAD for extracting the 1986 data.

Sincerely,

/s/ BARBARA HARVEY
Barbara Harvey, Director
Staff Services

BH:das
c: Lelia Wright
Steve McAdoo
Jim White

March 19, 1987

Our Reference: DPO-R6-3:MF
CP-OUP

Ms. Lelia Wright
Vice-President
Medicare
Texas Blue Cross-Blue Shield
Post Office Box 660156
Dallas, Texas 75266-0156

Dear Lelia:

This is in response to Barbara Harvey's letter of March 9, 1987 to Magda Flores concerning the proposed budget for identifying and collecting overpayments that resulted from using fees instead of profile data.

It is our understanding that the BMAD specifications will be out shortly, and as using this data would result in a significant savings, we believe it would be best to wait and use it.

We discussed the proposed budget with Pete Lozoya who indicated that the amounts were not included in your supplemental budget request. Thus, it will be necessary to request the funding through the normal supplemental budget process. If you have any questions concerning budgets, please call Pete at 767-6493.

If you have any additional questions concerning the overpayment recoupment effort, call Magda at 767-6441.

Sincerely,

Lanny S. Day, Chief
Policy and Technical
Assistance Branch

bcc:
Steve McAdoo, Onsite Specialist
Pete Lozoya, DFO
Official and Reading Files
DPO/MFlores/mjm—Disc #49—TBC—F3/19

I.C.

July 23, 1987

Our Reference: DPO-R6-3:MF
CP-OUP

Ms. Lelia Wright
Vice-President
Medicare
Texas Blue Cross-Blue Shield
Post Office Box 660156
Dallas, Texas 75266-0156
Attn: Linda Parker

Dear Lelia:

This letter is a followup to a conversation between Linda Parker and Magda Flores concerning the overpayment letters to be sent to physicians and beneficiaries who were overpaid as a result of the conversion to HCPCS and subsequent fees.

Because the services were rendered prior to January 1, 1987, the new appeals language which references an administrative law judge need not be used.

The fourth paragraph in the beneficiary letter, i.e., "You may want to knew the Medicare laws and guidelines . . ." may be deleted from this special letter.

The letter should include an explanation of the HCFA/ SSA waiver of recovery provisions. (See Section 7118.)

Also, while this was not discussed on the phone, we noted that there is no language regarding the beneficiary's or physician's right to a review. (See Section 12100.12B.2) The letters should include a right to review as some parties will not have met the $100 tolerance to qualify for a hearing.

If you have any questions, call Magda at 767-6441.

Sincerely,

Lanny S. Day, Chief
Policy and Technical
Assistance Branch

bcc:
Steve McAdoo, Onsite Specialist
Official and Reading Files
DPO/MFlores/mjm—Disc #55—tbc—F7/23

Dear Doctor _____:

As you were informed in Special Newsletter No. 49 dated March 14, 1986, several codes were incorrectly converted and placed on fees during the HCPCS conversions. These incorrect conversions resulted in overpayments being made. We have now been instructed by the Health Care Financing Administration that we must recover these monies. Attached is a list of your claims that were involved in the overpayment. Our records show an excess payment of $_____ occurred from July 7, 1985 to April 1, 1986 for which we must now request a refund.

You are required to refund the $_____ with a check or money order within thirty days. This should be made out to "Medicare Part B" and mailed in the enclosed envelope.

If other Medicare claims are paid and you have not refunded the money, this amount will be taken from any payment you would receive. This will begin thirty days from the date of this letter.

Section 117 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) provides that interest will be charged on overpayments not liquidated within thirty days of the date of the final determination of the overpayment.

If this overpayment has not been paid in full, interest will be assessed on the balance thirty days from the date of this letter. These procedures will not affect the normal withholding of benefits.

You may request a hearing if you do not agree with this decision. You must request a hearing within six months of the date of the letter. The amount of benefits in question must be $100 or more in order to have a hearing. To meet the $100 you may combine the amounts for any claims on which we made a determination within the

past six months based on (1) a request for review or (2) a reopening of an initial or review determination.

Write to us or contact a Social Security Office if you want a hearing. If you can, please include with your request the following:

1. Copies of your claim form
2. Explanation of Medicare Benefits form
3. A copy of this letter

You may attend the hearing in person. You may also take or send someone to represent you. This person may be a lawyer or anyone you choose. Please note on your request who will attend the hearing. You do not have to appear in person. You may ask that a decision be made based on the information in the file. A copy of the decision will be sent to you.

Fair Hearing Department—Medicare Part B
P.O. Box 660031
Dallas, Texas 75266-0031

Thank you for your time and help in this matter.

Sincerely,

Attachment

Dear _____:

In 1985 Medicare converted to a new coding structure. During this change several codes were changed incorrectly and placed on fees. This caused claims billed for these codes to be overpaid. Upon instructions received from the Health Care Financing Administration we must now ask that you refund the monies you were overpaid on your claims. Attached to this letter is a printout showing each payment.

Our records show an excess payment of $_____ occurred from July 7, 1985 to April 1, 1986 for which we must now request a refund.

You may refund this overpayment by attaching a check or money order to this letter and returning it to our office. The check or money order should be made payable to Medicare Part B.

[NOTE: The following paragraph was stricken in the Original Letter].

You may want to know the Medicare law and guidelines that apply. You can obtain copies by writing us.

You may request a hearing if you do not agree with this decision. You must request a hearing within six months of the date of the letter. The amount of benefits in question must be $100 or more in order to have a hearing. To meet the $100 you may combine the amounts for any claims on which we made a determination within the past six months based on (1) a request for review or (2) a reopening of an initial or review determination. Write to us or contact a Social Security Office if you want a hearing. If you can, please include with your request the following:

1. Copies of your claim form
2. Explanation of Medicare Benefits form
3. A copy of this letter

You may attend the hearing in person. You may also take or send someone to represent you. This person may be a lawyer or anyone you choose. Please note on your request who will attend the hearing. You do not have to appear in person. You may ask that a decision be made based on the information in the file. A copy of the decision will be sent to you.

Fair Hearing Department—Medicare Part B
P. O. Box 660031
Dallas, Texas 75266-0031

Thank you for your time and help in this matter.

Sincerely,

Attachments

Dear Doctor _____:

As you were informed in Special Newsletter No. 49 dated March 14, 1986, several codes were incorrectly converted and placed on fees during the HCPCS conversions. These incorrect conversions resulted in overpayments being made. We have now been instructed by the Health Care Financing Administration that we must recover these monies. Attached is a list of your claims that were involved in the overpayment. Our records show an excess payment of $_____ occurred from July 7, 1985 to April 1, 1986 for which we must now request a refund.

You are required to refund the $_____ with a check or money order within thirty days. This should be made out to "Medicare Part B" and mailed in the enclosed envelope.

If other Medicare claims are paid and you have not refunded the money this amount will be taken from any payment you would receive. This will begin thirty days from the date of this letter.

Based on the overpayment calculation the reasonable charge allowance has been reduced to $_____; therefore, the beneficiary's liability is now limited to $_____. This represents the 20% coinsurance of the new allowable charge. If you have collected more than this amount, the excess needs to be refunded to the beneficiary in accordance with the assignment agreement.

Section 117 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) provides that interest will be charged on overpayments not liquidated within thirty days of the date of the final determination of the overpayment.

If this overpayment has not been paid in full, interest will be assessed on the balance thirty days from the date of this letter. These procedures will not affect the normal withholding of benefits.

You may request a hearing if you do not agree with this decision. You must request a hearing within six months of the date of the letter. The amount of benefits in question must be $100 or more in order to have a hearing. To meet the $100 you may combine the amounts for any claims on which we made a determination within the past six months based on (1) a request for review or (2) a reopening of an initial or review determination. Write to us or contact a Social Security Office if you want a hearing. If you can, please include with your request the following:

1. Copies of your claim form
2. Explanation of Medicare Benefits form
3. A copy of this letter

You may attend the hearing in person. You may also take or send someone to represent you. This person may be a lawyer or anyone you choose. Please note on your request who will attend the hearing. You do not have to appear in person. You may ask that a decision be made based on the information in the file. A copy of the decision will be sent to you.

Fair Hearing Department—Medicare Part B
P. O. Box 660031
Dallas, Texas 75266-0031

Thank you for your time and help in this matter.

Sincerely,

Attachments

PART B

BLUE CROSS AND BLUE SHIELD OF TEXAS, INC.
P.O. BOX 660156
DALLAS, TEXAS 75266-0156
DALLAS/FORT WORTH METRO NO. (214) 647-2282
TOLL FREE NO. 1-800-442-2620 (TEXAS ONLY)

OCTOBER 15, 1980

IN ANY INQUIRY REFER TO—0095-1001999490
HEALTH INSURANCE CLAIM NUMBER—
449701550A

MR. TEX LONGHORN
12345 NORTH CENTRAL EXPRESSWAY
BIG "D", TEXAS
666660000

EXAMPLE LETTER 045

ON MARCH 29, 1975 WE MADE A PAYMENT TO ALPHABETIC INFORMATION FOR SERVICES PROVIDED TO YOU FROM MARCH 29, 1975 TO MARCH 29, 1975. THIS CLAIM WAS FOR ALPHABETIC INFORMATION IN THE AMOUNT OF $999.99. WE HAVE FOUND THAT THIS CLAIM IS OVERPAID IN THE AMOUNT OF $999.99, WHICH IS 80 PERCENT OF $999.99. THIS WAS BECAUSE ALPHABETIC INFORMATION.

ALPHABETIC INFORMATION HAS BEEN REQUESTED TO REFUND THE MONEY.

SINCE THE CLAIM WAS OVERPAID, THE ALLOWABLE CHARGE HAS BEEN REDUCED TO $999.99. THEREFORE, THE PROVIDER OF SERVICES CAN ONLY CHARGE YOU A REDUCED COINSURANCE AMOUNT (AND DEDUCTIBLE AMOUNT, IF ANY) OF $999.99 ON THIS BILL (AND NONCOVERED SERVICES). IF THE PROVIDER OF SERVICES HAS COLLECTED MORE THAN THIS AMOUNT, HE IS REQUIRED TO REFUND THE REST.

YOU MAY REQUEST A HEARING IF YOU DO NOT AGREE WITH THIS DECISION. YOU MUST REQUEST A HEARING WITHIN SIX MONTHS OF THE DATE OF THE LETTER. THE AMOUNT OF BENEFITS IN QUESTION MUST BE $100 OR MORE IN ORDER TO HAVE A HEARING. TO MEET THE $100 YOU MAY COMBINE THE AMOUNTS FOR ANY CLAIMS ON WHICH WE MADE A DETERMINATION WITHIN THE PAST SIX MONTHS BASED ON

1. A REQUEST FOR REVIEW OR
2. A REOPENING OF AN INITIAL OR REVIEW DETERMINATION

WRITE TO US OR CONTACT A SOCIAL SECURITY OFFICE IF YOU WANT A HEARING. IF YOU CAN, PLEASE INCLUDE WITH YOUR REQUEST THE FOLLOWING:

(1) COPIES OF YOUR CLAIM FORM
(2) EXPLANATION OF MEDICARE BENEFITS FORM
(3) A COPY OF THIS LETTER

YOU MAY ATTEND THE HEARING IN PERSON. YOU MAY ALSO TAKE OR SEND SOMEONE TO REPRESENT YOU. THIS PERSON MAY BE A LAWYER OR ANYONE YOU CHOOSE. PLEASE NOTE ON YOUR REQUEST WHO WILL ATTEND THE HEARING. YOU DO NOT HAVE TO APPEAR IN PERSON. YOU MAY ASK THAT A DECISION BE MADE BASED ON THE INFORMATION IN THE FILE. A COPY OF THE DECISION WILL BE SENT TO YOU.

FAIR HEARING DEPARTMENT—MEDICARE PART B
P.O. BOX 660031
DALLAS, TEXAS 75266-0031

A COPY OF OUR LETTER TO THE PROVIDER OF SERVICES IS ATTACHED. IF WE CAN BE OF SERVICE, PLEASE LET US KNOW.

THANK YOU FOR YOUR TIME AND HELP IN THIS MATTER.

SINCERELY,

PATTY MAXEY
BENEFIT SERVICE
REPRESENTATIVE

I.D.

AUG 28 1987

Our Reference: DPO-R6-3:MF
CP-COD

Ms. Lelia Wright
Vice-President
Medicare
Texas Blue Cross-Blue Shield
Post Office Box 660156
Dallas, Texas 75266-0156

Dear Lelia:

This letter is to confirm the procedures that we are asking you to implement regarding the HCPCS Overpayment Recoupment Project.

Do not attempt to recover by offset any physician overpayments until the procedures outlined below have been accomplished.

Section 7130A. of the Medicare Carriers Manual instructs carriers *not* to mention the possibility of installment payments when requesting overpayments from physicians. However, we believe that it would be in the best interest of the Medicare program for you to immediately issue a letter to all physicians involved in the overpayment advising them of the availability of extended repayment schedules. We are furnishing to you the language concerning installments that should be included in the letter. While we would prefer that you mail the letter only to those physicians who have not already refunded the amount in controversy, the carrier may, if necessary, mail the letter to all physicians involved in the overpayment. Any physician who has already refunded the overpayment would not have the option of repaying in installments.

If within 40 days of the date of the above letter, a physician either has not requested an extended payback schedule or complied with the instructions outlined in the letter, you should initiate offset. (NOTE: The letter will continue to say that offset will take effect within 30 days of the letter; the 40 days is to allow for mail plus internal handling and crediting of refunds per MCM 7130E.) If a physician requests an extended payback schedule, the request should be accompanied by the first installment payment. If no installment payment accompanies the letter, then offset should be initiated assuming the 40 day period has elapsed.

We have no estimate of the number of physicians who may elect this option, but the carrier should not initiate offset on an individual physician until after it has evaluated the request and notified the physician of its decision.

For overpayments not liquidated within 30 days, interest will accrue from the date of this second demand letter except for ophthalmologists as noted below.

This notice will also serve as the follow-up request mandated by MCM 7130D., so the carrier should follow the rules outlined in that paragraph including attaching a copy of the initial letter.

The carrier should notify all physicians who billed codes 66983 and 66984 that due to the confusion surrounding the proper billing of the codes during this time, their overpayment calculation may be in error. If they billed incorrectly because they believed that the 66983 was the proper code to bill for the phacoemulsification, they should immediately (within 30 days) notify you by letter and be prepared to support their contention with documentation such as operative reports. The evidence need not accompany the initial notification but should follow shortly. The carrier should not initiate offset or take any action to recoup the overpayment until it has evaluated the evidence and recalculated the overpayment (if necessary). Once the review is complete, the carrier should

initiate a corrected overpayment demand letter. If the overpayment is not refunded within 40 days (see NOTE) of this letter or the physician has not submitted a request for an extended repayment schedule, the carrier should begin its offset procedures. Any interest charged to these physicians would accrue from the date of the letter notifying them of the recalculated amounts. However, if the carrier affirms its original decision, i.e., the initial overpayment amount is correct, interest would accrue from the date of the letter informing them of the availability of installment payments.

The procedures in the preceding paragraph apply only if the physician notifies the carrier that he billed codes 66983/66984 incorrectly and furnishes documentation. If a physician does not notify you that he may have billed incorrectly, the carrier should follow the procedures in effect for all other physicians.

Also, until further notice, the carrier should include the language on installments in all future initial overpayment letters.

If you have any questions concerning this letter, please call Magda Flores at 767-6441 or Steve McAdoo.

Sincerely,

J.D. Sconce
Regional Administrator

Enclosure

bcc:
Linda Parker, TBC
Steve McAdoo
Official and Reading Files
DPO/MFlores/mjm—Disc #57—TBC—F8/27

DRAFT

A physician or supplier who has been overpaid has the option of repaying the Medicare program through one of the following procedures:

a. Send an immediate lump sum payment made payable to "Medicare Part B",

b. Have us withhold it from your Medicare payments, or

c. Repay through monthly installments.

You may elect to repay Medicare in installments if a lump sum settlement would cause you a financial hardship. A financial hardship may be determined to exist if a lump sum repayment would create a serious cash flow problem.

If you wish to refund in installments, you should submit within 30 days of the date of this letter your proposed monthly method of repayment accompanied by the first installment.

All installment payments will be applied first to accrued interest and then to the principal balance. The rate of interest is 7 percent through December 31, 1987 and will be applied to the total overpayment due beginning from the date of the initial letter advising you of the overpayment.

Any repayment schedule of 6 months or more must be contained in an executed promissory note.

If you have already repaid the amount, please disregard this letter.

I.E.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing
Administration

Regional Office VI
1200 Main Tower Building
Dallas, Texas 75202

October 5, 1987

Our Reference: BSB:R6-3:GH
BSB-TX-BC-BS

Ms. Lelia Wright, Vice President
Medicare
Blue Cross/Blue Shield of Texas
P. O. Box 660156
Dallas, Texas 75266-0156

Dear Lelia:

The following instructions apply only to those "reasonable charge reduction" overpayments involving payments made between July 1, 1985, through March 31, 1986 and for which *recovery is directed to the beneficiary.*

This region has been given administrative authority to arrive at equitable waiver determinations for a specific class of overpayment cases. These cases will require a disposition decision and written notification to the beneficiary (see enclosure). No additional carrier development will be necessary.

The specific class of cases mentioned above consists of beneficiary overpayments of $200.00 or less for which waiver has been requested. In the absence of evidence to the contrary without fault will be deemed met. All beneficiary overpayments of $200.00 or less in which

the beneficiary requests waiver or expresses inability to repay will be waived. Carrier personnel will perform this function by completing the enclosed letter and routing it to the HCFA onsite representative for signature. Documentation of these waiver decisions including copies of all correspondence should be retained by the carrier until further notice.

In addition to the above, pursuit of overpayments to deceased beneficiaries should be discontinued.

Cases that do not fall within the above groups should be pursued for recovery in accordance with appropriate manual instruction.

These instructions are "one time only" instructions and apply only to those overpayments cited in the first paragraph. Please contact Gerald Halyard or Magda Flores at 767-6401, if you have any questions concerning this directive.

Sincerely,

/s/ B. E. McCUTCHEN
for J. D. Sconce
Regional Administrator

Enclosure

Date

_____

_____

_____

_____

Dear:

We recently received an inquiry from you concerning the Medicare overpayment made to you in the amount of $_____.__. Texas Blue Shield had previously informed you of the overpayment amount and requested a refund. We have reviewed your case and have determined that recovery of the overpayment should be waived. Therefore, you will not be required to repay this amount. No further action is required on your part.

We regret any inconvenience that this may have caused you.

Sincerely,

J.D. Sconce
Regional Administrator

I.F.

Texas Blue Shield Instructions

Processing the Beneficiary-Recovery Reasonable Charge Reduction Overpayments for the Period July 1985 - March 1986.

The carrier should set up files for any papers (particularly, correspondence) by whichever method is easiest to retrieve under its system: HICN or name. Those disposed of under these instructions should be annotated as specified below and filed there for whatever period the regional office (RO) specifies. They should be treated for records and reports as if they had been forwarded to central office Overpayment Section (CO OPS) under MCM 7142ff.

Review all beneficiary-recovery cases for possible disposition under the criteria in 1-4, below. When a case is disposed of under one of the categories, annotate the reason as specified below and file the case. If the overpayment is completely recouped, it may be treated as any other overpayment recovery.

1. If it is a beneficiary-recovery case because the assignee is without fault, close the file by marking it, "Recovery waived per CO memorandum of 10/21/87." (Normally, these would be referred to CO before attempting recovery per MCM 7116H.) These are waiver of recovery cases based on "against equity and good conscience" (unfairness), not on finacial hardship. Where a beneficiary expressly or implicitly requested waiver based on financial hardship and you cannot dispose of it under any of the other four bases below, refer it to CO OPS. If you can dispose of it, tell the beneficiary he/she need not repay it.

For items 2, 3, or 4, mark them "Recovery terminated per CO memorandum dated 10/21/87," and file them.

2. Overpayments less than $50 (include all those pending for any one beneficiary).
3. If you have reliable evidence of the beneficiary's entitlement to SSI, Medicaid, any other governmental financial assistance, or based on financial hardship.
4. If a beneficiary is deceased.

If a case cannot be disposed of under the above instructions: It should be reviewed to be sure the cause and computation have been clearly explained. A minimum of information for each item involved would be 1) the original total charge; 2) the original and revised allowable charge; 3) any applicable deductible and/or coinsurance; 4) the prior and revised Medicare payment and the amount due; and 5) if there is more than one item, the total amounts due.

I.G.

Texas Blue Shield Instructions

Processing the Beneficiary-Recovery Reasonable Charge Reduction Overpayments for the Period July 1985 - March 1986.

The carrier should set up files for any papers (particularly, correspondence) by whichever method is easiest to retrieve under its system: HICN or name. Those disposed of under these instructions should be annotated as specified below and filed there for whatever period the regional office (RO) specifies. They should be treated for records and reports as if they had been forwarded to central office Overpayment Section (CO OPS) under MCM 7142ff. (For the exception on automatic appeal reversals, see instruction 5, below.)

Review all beneficiary-recovery cases for possible disposition under the criteria in 1-5, below. When a case is disposed of under one of the categories, annotate the reason as specified below and file the case. If the overpayment is completely recouped, it may be treated as any other overpayment recovery.

1. If it is a beneficiary-recovery case because the assignee is without fault, close the file by marking it, "Recovery waived per CO memorandum of 9/23/87." (Normally, these would be referred to CO before attempting recovery per MCM 7116H.) These are waiver of recovery cases based on "against equity and good conscience" (unfairness), not on financial hardship. Where a beneficiary expressly or implicitly requested waiver based on financial hardship and you cannot dispose of it under any of the other four bases below, refer it to CO OPS. If you can dispose of it, tell the beneficiary he/she need not repay it.

For items 2, 3, or 4 mark them "Recovery terminated per CO memorandum dated 9/23/87," and file them. Accept any payments received, but do not followup for any unpaid amount.

2. Overpayments less than $200 (include all those pending for any one beneficiary).
3. If you have reliable evidence of the beneficiary's entitlement to SSI, Medicaid, or any other governmental financial assistance based on financial hardship.
4. If a beneficiary is deceased.
5. If the overpayment is $500 or less and the beneficiary requests a review, give an automatic overpayment reversal determination and treat this case as an appeals reversal for filing and/or disposition. (If the appeal is received after the case was referred to CO OPS, forward the request giving the date and cover sheet number by which it was forwarded.) Any appeal requests for beneficiary-recovery overpayments over $500 that cannot be disposed of under criteria 3 or 4 should follow the usual appeal procedures. (If it has already been referred to CO OPS, ask for the file to be returned or to be advised if recovery has been waived.)

If a case cannot be disposed of under the above instructions: It should be reviewed to be sure the cause and computation have been clearly explained. A minimum of information for each item involved would be 1) the original total charge; 2) the original and revised allowable charge; 3) any applicable deductible and/or coinsurance; 4) the prior and revised Medicare payment and the amount due; and 5) if there is more than one item, the total amounts due.

If no refund is received 60 days after a clear letter was sent and you cannot dispose of the case, send a brief follow-up letter (you can use a copy of the original letter

for most of the information). Thirty days after the follow-up letter or whenever the beneficiary requests waiver of recovery (expressed or implied), refer the file to CO OPS per MCM 7142ff, but shortened as follows.

For those cases that must be sent to central office:

> Prepare a list with up to 20 cases per cover sheet, typed or computer printed in duplicate, leaving at least one space between entries, with the following listed under this title and these headings:
>
> Texas Blue Shield (00900) CO Special Overpayment Referrals

HICN	Name	Overpayment Amount/Recouped	Dates of Services	Wavier Requested? Yes	No

- Under HICN, list all of those on one cover sheet in numerical order.
- Under Name, list last name first, first name and middle initial.
- Under Overpayment Amount, show the total amount due first. If any of the original amount was recouped, show the amount recouped next.
- Under Dates of Services, list the first and last dates of service involved in the overpayment.
- Under Waiver Requested? check "Yes" or "No." (Do the same if waiver is *implied.*)
- The following is a list of requirements to follow prior to your referral of these cases:
  - — Staple all correspondence for each beneficiary and attach to the list in HICN order.
  - — If the recovery letter does not provide a clear explanation of the overpayment cause and computation, give a separate explanation in the file.
  - — Date and number each transmittal sheet consecutively for ready referral.

II.A.

May 7, 1987

Lanny:

I met with Barbara Harvey, Linda Parker and Linda Lilly at "BS" today. We discussed the overpayment recoupment effort and identified the following concerns:

1. The carrier will be unable to send out all letters simultaneously. They anticipate it may take from 6 months to one year to send out all the letters. Linda P. explained that in addition to sending out the letter, the carrier must set up the accounts receivable (AR) in the system prior to sending out the letter in order to ensure that any money subsequently refunded is properly applied. Additionally, the carrier sets up the system to begin offsetting within 45 days of the date of the letter. Beneficiaries must be notified on an assigned case that they are not liable for any additional charges and that they may have a refund coming back on part of their coinsurance.

   According to Linda L., an experienced overpayment specialist can work about 6 cases per hour. Because the system has already done much of the development work for them, they should be able to do these more quickly, but it will still take time to verify the accuracy. They want to verify the accuracy manually in order to forestall problems such as they have had before.

   We talked about trying to speed up the process. The carrier plans to immediately sort the paper by provider and beneficiary. There are 9 boxes of provider overpayments and 3 boxes of beneficiary overpayments. It will send out the physician letters

first beginning with opthamologists. Bene letters will be last.

2. We discussed the letter to be sent. They will welcome our input. They will run it through their process including the BCBS general counsel.

   I told them to say "The HCFA Regional Office has directed us to recoup" or language to that effect if they wanted to.

3. An explanatory statement will accompany the bene letter to help them interpret the attachment. Perhaps one should also go with the physician letter.

4. I asked that they clarify on the physician attachment that beneficiary overpayment did not mean that the bene was liable.

5. I'm to check with DFO about possible installment plans for physicians up front or reduced percentage on offset, e.g., 50% as opposed to 100%

/s/ Magda

II.B.

August 28, 1987

I met with Lelia Wright, Jim White, Barbara Harvey, Linda Parker of Texas Blue Shield and State McAdoo today.

I hand carried and discussed our August 28 letter outlining the procedures for installing offset and assessing interest on the overpayments. It was an unsigned copy. We discussed it at length. The carrier should be able to comply with it.

They will try to get the system to do what we have asked by asking it to add 45 days to the Julian date of the letter.

We asked that the letters be sent out as soon as possible and they agreed. Linda says that they will be able to prevent sending the installment letter to most of the physicians who have already repaid because of the way it's set up. When they send the first letter, they copy it and file it. As a refund is received, they pull the letter. The followup letter is simply a copy of the first with a stamped annotation that it's a followup.

We discussed the procedures for cataract surgeons. Steve questioned whether other physicians would object if they were not given equal rights. Linda said she'd already received requests from physicians who want her to reopen other claims or look at other issues in light of the overpayment. We all agreed that it would be best for TBS to draft a form letter notifying physicians that any codes/problems outside of the overpayment should be handled as a separate issue. Issues pertinent to the codes in question for the time period in question would be reviewed in light of the overpayment.

A code in question for ophthalmologists is the 90060. Generally, an opthamologist would bill a 92012. However, one consultant has already identified a client who billed the 90060 and did not change the code because there was

no money difference. We did not come up with a decision; however, I feel we should be as equitable as possible.

Steve said that the carrier has already received a number of fair hearing requests.

A question raised by Beneficiary Services was whether the carrier planned to reissue corrected EOMBs. The carrier does not plan to but will write a form letter which it will send on request telling an insurance company that the information already presented on the attachment to the original letter and the original letter contains all the information that would be contained on an EOMB. They do not believe they can handle preparing manual EOMBs for all beneficiaries at this time.

Some benes are requesting the original EOMBs which have already been purged and are in storage. Unless we have some regulation which requires that the carrier produce these, I am not willing to require the carrier to do so.

We discussed the reduced coinsurance issues. One, the doctor letter did not include that language; future letters will. Two, can we tell doctors who call that they do not have to develop any coinsurance benefits due to benes if its under $5? That's the HCFA tolerance (MCM7200). This sounds reasonable to me.

Other items mentioned:

Mentioned Mary Powers, legislative liaison for AARP, and her call.

They mentioned tape of doctors/addresses was ready for pickup by Southwest.

Linda said total collected to date was $553,458.

Mentioned benes wanted to subtract now from social security benefits; not an alternative.

We should always give benes benefit of the doubt.

Span of doc letters is from 8/4 to 8/22 (not all bene letters are out); all docs are.

Magda

II.C.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

MEMORANDUM

Refer to: BPO-F43

October 14, 1987

Chief
Beneficiary Debt Management Branch, DOP, OFO, BPO

Beneficiary-Recovery Overpayments - Texas Blue Shield (Memo, dated 9/23/87 from Sam Guida)

Associate Regional Administrator
Division of Program Operations
Dallas

As we advised, we are providing instructions to accompany the temporary authority to dispose of some of the beneficiary-recovery, reasonable charge reduction overpayments identified by the carrier. Inequity and extra costs incurred in an abnormally large number of such overpayments justify the criteria for reducing the workload.

We understand that the carrier has sent the initial letters, so we assume that the initial assignee fault determinations have been made. This affects processing of beneficiary-recovery overpayments when the assignee is without fault.

The attached, along with this memorandum, should reduce the processing time and the number of cases that need to be referred to central office Overpayment Section.

If there are any questions, contact Montrell Spence at FTS 987-3372.

/s/ THOMAS CASTELLO
Thomas Castello

Attachment

II.D.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Financing Administration

MEMORANDUM

Refer to: BPO-F4

Date
October 21, 1987

From
Director
Division of Overpayment Prevention, OFO, BPO

Subject
Beneficiary Recovery Overpayments—
Texas Blue Shield

To
Associate Regional Administrator
Division of Program Operations
Dallas

I regret the delay in finalizing my draft memorandum of September 23. After receiving comments from your office and the Office of the General Counsel, we have determined that the following procedures should be used:

In the handling of approximately 15,000 beneficiary overpayment cases, I am requesting that you use the following administrative authority, on my behalf, (as opposed to discretionary authority) in arriving at equitable determinations on these cases.

In the following class of cases, the beneficiary's overpayment recovery should be waived:

— Those assigned cases where the physician is without fault.

In the following class of cases, collection should not be pursued:

— Those that are $50 or less.

— Those who are currently receiving public financial assistance or who can otherwise demonstrate financial hardship.

— Those deceased.

Cases that do not fall within any of the above classes, or those where an appeal has been requested, should be processed in accordance with appropriate manual instructions.

This administrative authority may only be used for those "reasonable charge reduction" overpayments involving payments made between July 1, 1985, through March 31, 1986, and *for which recovery is directed to the beneficiary*. These overpayments are identified by code in your memorandum dated September 16, 1987.

Attached are the final instructions for processing these cases.

/s/ SAMUEL N. GUIDA
Samuel N. Guida

Attachment

when we finally completed it showed clearly that there had been an error and a mistake made on the face of it or whatever. So clearly if it's an error, which this definitely was, we feel we have up to four years to reopen and correct that.

Q. Well, Mr. Sconce, you just said "an error on the face or whatever", that's in quotes. What you do you mean an error on the face?

A. I believe our manual guidelines say that generally you can reopen up to one year for any reason, and that after that first year you have up to four years for various reasons. One of them is if you find an error, and I don't know the other reasons.

Q. What kind of error?

A. Any kind of an error that caused the taxpayers to pay out money that they shouldn't have paid out.

Q. Even if it's an error made completely within the Medicare system?

A. Any error that results in an incorrect payment.

Q. Are there any exceptions that you know of?

A. Not that I know of. If we conclude that an error has been made and improper payment has been made we are supposed to adjust it and we are doing that almost every hour on the hour throughout the United States.

Q. Who made the decision to actually seek recovery

of these alleged overpayments involved in the overpayment project from providers?

A. I did.

Q. Is there any document that would tell us when you made that decision?

A. I don't know if it's—if there is a written document or not. If there was it's probably in our files.

Q. Did you also make the decision to seek repayment of the alleged overpayment from Medicare beneficiaries?

A. Yes, I did, as we are required to do under law.

Q. Did you make that decision at the same time as the decision regarding providers?

A. Yes.

Q. Did you base both decisions on the same information?

A. Yes.

Q. Were the decisions in all respects identical decisions; that is, were all the same criteria considered no different between the two of them?

A. In terms of the fact that a mistake had been made and that claims had been paid at rates that they shouldn't have been paid at the decision was the same.

Q. Between the end of January of 1986 and whenever the date that you decided to go ahead and try to recover the money whenever that date may have been—

II.F.

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QUESTIONS AND ANSWERS ON THE TEXAS OVERPAYMENT

1. How did the overpayment occur?

   In July 1985, the Texas carrier converted from its 4-digit (7500 codes) coding system to the 5-digit (20,000 codes) HCFA Common Procedure Coding System (HCPCS). Some of the conversions, while logical based on code nomenclatures, created inequities in pricing because of the historical billing patterns of physicians prior to the conversion. The carrier became aware of the inequities because of the number of complaints from physicians who were getting less for the same procedure than they had received prior to the conversion. Since it would have taken some time for the carrier to reprogram its computer to correct the inequities, it selected statewide fees for each affected procedure so the processing of claims would not be delayed. The carrier expected to correct the payment amounts during the October 1, 1985 reasonable charge update which was delayed until May 1, 1986 because of Congressional action. The fees, generally, were set at the highest prevailing in the state, creating overpayments on those procedures when billed from localities of the state where allowables should have been lower.

2. When was the problem discovered?

   The Health Care Financing Administration (HCFA) became aware of the problem in November 1985 and conducted a review in mid-December. We issued a report to the carrier in January 1986 and instructed that the fees be replaced with valid customary and prevailing charges as soon as possible. Most of the problems were corrected by March 31, 1986.

3. Why did it take so long to attempt to recover the overpayments?

   Initially, we were not sure that the amount of the overpayment would outweigh the cost of attempting to recoup it. Initial budget estimates to identify and recoup the amounts were about $2.5 million. Based on preliminary audits, we determined that the overpayment was significant and that an exact accounting was necessary. Once we learned the amount involved, we had no recourse but to instruct the carrier to recoup. Subsequent to this decision, several computer runs were required to purify the data and to ensure accuracy of the overpayment calculations.

4. Is there a time limit on recoupment?

   Generally, overpayments must be initiated within 3 calendar years after the year of payment.

5. Why is the carrier not being held liable for the overpayments?

   HCFA uses the standard of liability for erroneous benefit payments found in Section 1842(e) of the Social Security Act. According to that provision, contractors will not be held liable for erroneous payments except in cases of gross negligence or intent to defraud. The standard established by the Social Security Act recognizes that a large entitlement program such as Medicare will necessarily encounter some degree of human error and imperfection. Gross negligence is defined as "great or excessive negligence", "the absence of any care" and "reckless or wanton disregard". We do not believe the carrier's actions meet these criteria.

6. Why did the carrier issue Special Medicare Newsletter No. 49? Did HCFA approve the release? Does this not absolve physicians from repayment?

   The newsletter was to notify physicians that the correct payment limitations were to be used for the codes so that the carrier would not be inundated with questions concerning payments on these codes. At the time the newsletter was issued, we were not aware of the magnitude of the overpayment and felt that the administrative cost of identifying and collecting the overpayment would exceed the amount we could collect. (See Question 3.) However, once the amount was identified, we had no option but to collect. We are required to collect such overpayments once they are identified.

7. What are the options for beneficiaries in repaying the amounts?

METHODOLOGY USED IN CACULATING THE OVERPAYMENTS

Methodology for Physician Overpayment Identification

1. The following codes should be pulled from history if the paid date equals 7-1-85 through 3-31-86 and the claim type is 60.

1-90060	3-90642
1-90250	3-90643
2-66983	4-R0070
8-66983	4-R0075
2-66984	4-W7451
8-66984	4-74000
2-67908	I-74000
8-67908	T-74000
4-W7453	2-67143
4-W7460	1-M0022
3-90640	1-90784
3-90641	1-90798
	1-M0021

2. Two sorts of data will be required:

   A. Nonassigned claims—beneficiary sort:

      1) Sort by HIC,
      2) Page after each HIC,
      3) Secondary sort by procedure code,
      4) Aggregate and total overpayments by beneficiary for all procedure codes,
      5) Prepare a separate grand total of beneficiary overpayments of $50.00 or less,
      6) Prepare a separate grand total of beneficiary overpayments that exceed $50.00.

   B. Assigned claims—provider sort:

      1) Sort by billing provider number,
      2) Page after each provider,
      3) Secondary sort by beneficiary

4) Third sort by procedure code,
5) Subtotal by beneficiary,
6) Prepare a grand total of overpayments by provider that are $50.00 or less,
7) Prepare a grand total of overpayments by provider that exceed $50.00.

3. The actual allowed amount for each code should be compared to the lower of the customary or prevailing profile for the performing provider that would have been in effect for the date of service when each procedure was performed. Calculate the difference between the actual allowed amount and the profile amount. If the actual allowed amount is greater than the profile amount, calculate the overpayment at 80 percent or 100 percent of the difference based on the initial claim calculation.

4. Data elements to be reported:

A. Billing provider number,
B. Billing provider name,
C. Billing provider address,
D. HIC,
E. Beneficiary name
F. From dates of service (FDOS),
G. To dates of service (TDOS),
H. Submitted charge,
I. Type of service,
J. Procedure code,
K. Place of service,
L. Quantity allowed,
M. Paid amount,
N. Allowed amount,
O. Deductible applied,
P. ICN,
Q. Calculated overpayment amount,
R. Profile amount used to calculate overpayment,
S. Paid date,
T. Performing physician name and number,
U. Check #.

5. Deductible amount will need to be at the detail level of the claim, which means that the deductible from the header level will need to be allocated to the detail level.

6. Payment amount must be calculated on each detail —normal pricing should be followed, i.e., payment = allowed - deductible and coinsurance.

7. Produce a separate report which totals the overpayment by procedure code. Exclude beneficiary and provider overpayments of $50.00 or less from these totals.

8. Mailing labels should be produced from the system for each provider.

PROCEDURES FOR DISPOSITION OF CASES INVOLVING DECEASED BENEFICIARIES

1. If a representative of the estate remits the overpayment, process the overpayment in accordance with the requirements outlined in the Medicare Carriers Manual (MCM).

2. If a refund is not received within 30 days after writing the estate and the carrier has not received any communication from the estate, the carrier should close the case. It should annotate that the overpayment file is being closed in accordance with the administrative authority granted to the Regional Office. The case should not be forwarded to HCFA Central Office. No further action should be taken.

3. If a refund is not received within 30 days after writing the estate and the carrier has been contacted by the estate or someone representing the deceased beneficiary to protest the overpayment, the carrier should close the case and annotate the file. The case should not be forwarded to the HCFA Central Office. If the representative offers to repay the account, process the payment and close the case.

4. Generally, once the original letter has gone out, the carrier need not undertake any further development when the beneficiary is deceased.

SUMMARY OF TBS OVERPAYMENT

In July 1985, Texas Blue Shield converted to the 5-digit HCFA Common Procedure Coding System (HCPCS). At the time of the conversion it identified a number of problems with the conversion and the subsequent pricing of procedures. As a result, it erroneously removed the reasonable charge limitations from 16 codes and priced the procedures based on fees. When the carrier places a code on fee, it pays the lower of the submitted charge or the fee without regard to customary and prevailing charges. The carrier continued this payment pattern for six months for most of the procedures.

When my staff became aware of the situation, they conducted a review at the carrier. As a result of the review, we instructed the carrier to recoup the overpayments as appropriate. The carrier has identified an overpayment of $13.3 million. Over $6 million of the overpayment is for cataract procedures.

The carrier started mailing letters to providers on August 10 and anticipates that all letters (including those to beneficiaries) will be mailed by the end of next week. It has set up a telephone line to answer inquiries from physicians and beneficiaries.

We notified in writing the Texas congressional offices of the recoupment effort. In addition, we called the Texas Medical Association (TMA) and alerted them. We also sent them a copy of the letter sent to the congressional delegation.

III.A.

COLEMAN DEPOSITION

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subject procedure codes, that you continued to believe that you had done the right thing in 1985?

A. I said that, yes.

Q. Is it not correct that the carrier instructed—excuse me—that HCFA instructed the carrier first to take those 18 procedures off of statewide fees? Is that right?

A. Yes.

Q. Is it not also true that HCFA instructed the carrier at some point to go and attempt to recoup the money that had been paid to physicians and beneficiaries for some period on those 18 procedure codes?

A. Yes, that's correct.

Q. Were you a party to the decision to try and recover that money from the beneficiaries and providers?

A. No.

Q. How did you find out that that was going happen?

A. My first exposure to that was the meeting we had in Mr. Sconce's office when he said it amounted to $15 million, and that's the first exposure I had that HCFA made a decision that was more money than they could leave on the table.

Q. What is your best recollection of when that meeting occurred?

A. Late spring of 1987.

Q. Do you recall who was in attendance?

III.B.

BLUE CROSS
and
BLUE SHIELD
of Texas, Inc.
Post Office Box 660058
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(214) 669-6122

Rogers K. Coleman, M.D.
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David S. Sowell III, M.D.
Associate Medical Director
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August 14, 1987

Louis J. Goodman, Ph.D.
Director, Division of Medical Economics
Texas Medical Association
1801 North Lamar
Austin, Texas 78701

Dear Dr. Goodman:

This letter is to document the scenario surrounding the refund letters which have prompted calls to your office this past week. Some of this information was given to Anthony Chapple over the telephone, but I thought it worthwhile to include it in this letter.

When we converted to HCPCS in July of 1985 there were approximately 18 codes that were priced on a fee because they were the secondary choice in instances where two HCPCS or CPT codes converted to a single old Texas Medicare code. In those instances the fees priced represented fees very close to the average charge for the code to which they had a secondary match. When this endeavor was undertaken, it was the belief of the carrier that we had the approval of the Health Care Financing Administration who oversaw our HCPCS conversion to approach these problem areas in this manner. These codes were placed on statewide fees and priced without regard to customaries and prevailings. In early January of 1986 we were informed by the Regional Office that a study performed by their audit section had determined that there were overpayments being made to physicians whose charges were higher than either their customary and prevailing by virtue of the fee schedule arrangement.

We were instructed at that time to immediately implement customary and prevailing profiles for the codes in question. This was accomplished in the early spring of 1986. We informed providers in our special Medicare Newsletter #49 mailed March 14, 1986, and I quote, "Adjustments and/or overpayment requests will not be recognized by the carrier."

As you are aware, Mr. J. D. Sconce, Regional Administrator of the Health Care Financing Administration, notified the Congressmen and Senators from Texas of the overpayment and of the intent to secure recovery of overpayments made. The carrier was instructed earlier this month to implement the recovery program. The letters were designed by a recovery unit located in our Denison office and were sent to physicians and beneficiaries who had received overpayments through this mechanism.

It is my understanding that there are approximately 5900 physicians involved and amount of moneys being recovered from physicians is in the range of $11,000,000.

The 18 procedure codes (with some duplication because of a change in type of service designator) are as follows:

M0021	had $591,548.42 in overpayments; the description is "Per Diem Inpatient Hospital Care"
M0022	had $277,017.37; it has a description of "Daily ICU Follow-up Care"
R0070	had $21,627.91; the description is "Transportation Charge, Portable X-Ray to Home or Nursing Home, First Patient Seen"
R0075	had $2,058.63; "Transportation Charge for Portable X-Ray Supplier, More Than One Patient Seen - Per Patient"
W7451	had $164.41; the description is "Transportation of Portable X-Ray and Personnel - 2 Patients Seen"
2-66983	Had $2,257,744.29; this is "Intracapsular Cataract Extraction with Intraocular Lens Implant"
8-66983	had $76,529.40; this is the Assistant Surgery for the above code
2-66984	had $4,551,415.74; this is an "Extracapsular Cataract Extraction with Insertion of Intraocular Lens"
8-66984	had $130,720.18; the Assistant Surgery for the above code
67143	had $865.60; "Prophylactic Cryotherapy for Retinal Detachment"
67908	had $11,545.20; it is a "Conjunctivo-tarsolevator Resection for Blepharoptosis"
1-74000	is $46,983.73; the description is "Interpretation of Abdominal X-Ray"
4-74000	$10,578.79 and it is "Total Component of an Abdominal X-Ray Including Professional and Technical Component"
90060	had $1,150,712.72; it is an "Office Visit - Intermediate Complexity"
90250	$2,360,806.72; it is an "Hospital Visit, Limited"

90640	$31,049.73; it is a "Follow-Up Consultation Brief"
90641	had $43,138.25; it is a "Follow-Up Consultation Limited"
90642	had $26,967.87; it is a "Follow-Up Consultation, Intermediate"
90643	had $55,255.91; "Follow-Up Consultation, Complex"
90784	had $8,189.16; "IV Injection of Medication"
90798	had $308.60; "IV for Severe or Intractable Allergic Disease"

Copies of the letters sent to doctors and/or beneficiaries are enclosed. The address on the letterhead is not the preferred address and this has been changed to be more correct. The proper address for correspondence to go to register complaints, protests, or documentation that the refund may be in error should be sent to:

Overpayments
2412 West Morton
Denison, Texas 75020

As I expressed to Anthony, I think it is an unusual incidence when the carrier becomes involved in soliciting refunds, and neither of us in the Medical Division was aware of the intricacy of the problem. I am sure that our Medicare Division did give us some information that something of this nature was in the works, but the magnitude of the situation and the intricacies of what it was all about were not apparent to me nor to other physicians in the Medical Division. This is unusual but certainly can occur. The medical Division does not have line authority in our Medicare operation. That is not a criticism on my part, it is simply a statement of fact. We are all physically housed in the private business side of the building. We have a part-time office in the Medicare operation that is used by those of us who go over for consultative endeavors. In those consultative endeavors we do answer the questions put to us, and assist them in any way we

can to make the system work best for physicians and the Medicare program.

At this point in time I do not know how many carriers suffered some of the same difficulties that the Texas carrier has suffered; I do not know if there have been requests for overpayments in other states as a result of the transition from an old coding system to HCPCS. I am very aware of the discomfort of the physicians' community over having letters reach beneficiaries prior to the time they reached the physicians. I can assure you that the physicians' letters were mailed three days in advance of the beneficiaries' letters, so that there was some thought given to having the doctors notified before the patients received a copy of overpayment situations; in spite of this planning, there were instances in which beneficiaries received letters before the doctor was notified that an overpayment request was in the mail.

Please let me know if you have any questions or comments concerning this sensitive matter.

Respectfully yours,

/s/ ROGERS K. COLEMAN, M.D.
Rogers K. Coleman, M.D.
Vice-President, Medical Director

RKC:jh

encls.

cc: David Vanderpool, M. D., President
Texas Medical Association

Al Hendler, M.D., Chairman
Hospital Medical Staff Section

John Selby, M. D., Chairman
Council on Socio-Economics

II. Documents Furnished by BCBST

BLUE CROSS
and
BLUE SHIELD
of Texas, Inc.
P.O. Box 660030
Dallas, Texas 75266-0030
214/669-7415

Lelia Wright
Division Manager
Medicare

March 10, 1986

Health Care Financing Administration
Mr. Lanny S. Day
Chief Policy and Technical Assistance Branch
1200 Main Tower Building
Dallas, Texas 75202

Dear Lanny:

We have completed our review of the pricing problems outlined in your letter of January 22, 1986.

Following are our comments:

In most cases, we agree that the fees need to be eliminated and profile transferred, which we had planned to incorporate with profile update on 10-1-85. Due to the physician fee freeze, profiles were not updated and transfer of profiles did not occur. Of the 33 codes in your letter, no change was necessary on numbers 16, 17, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31 and 32 because the EI had been applied in calculating the fee.

We disagree with your recommended action on the following codes which are numbers 5, 6 and 33.

A0220 & A0223 (ambulance ALS base-rate)

We believe token and extremes as well as incorrect billing of Texas codes 6000, 6002, 6012 and 6013 have contributed to a distorted profile build. In many cases, base rate has built higher than flat rate codes. Verification of 14 localities that billed BLS ambulance services showed allowances ranging from $40 to $125 depending on the locality billing. ALS ambulance services allowances range from $50 to $143.50. We rearrayed all four Texas codes pulling in some valid token and extreme information to hopefully bring the allowable charges in line with the charges submitted. As a result of our review, we propose leaving the ambulance codes on fee with increases and decreases as noted below:

	Current Fee	*Increased Fee*	
A0220	$143.50	$221.50	
A0223	$125.00	$185.00	
*A0010	$125.00	$ 90.00	reduced fee
*A0150	$125.00	$ 90.00	reduced fee
*A0222	$125.00	$ 90.00	reduced fee
*Y6002	$110.00	$ 90.00	reduced fee

*HCFA did not recommend action on these codes

Incidentally, we checked with two other carriers in our region and determined our proposed increased fees for ALS would continue to allow less than allowances reimbursed at the other two carriers.

90640 to 90643 (follow-up consultations)

We believe these codes are most often used in place of follow-up hospital visits rather than office visits; and it would be preferable to transfer hospital visit profiles, rather than office visits into the follow-up consultation codes.

We have compared hospital allowables to office visit allowables for specialties 02, 06, 08 and 11 in the Dallas, Tarrant, Bexar, Harris, Regions 02, 03 and 04 localities.

Based on our comparison we recommend transferring profiles as follows:

1-9024 to 3-90640
1-9025 to 3-90641
1-9025 to 3-90642
1-9027 to 3-90643

As an aside, the fees that were established for W7451, W7453, W7460, on HCFA's list, were implemented with HCFA's approval. At the time of HCPCS conversion we had not anticipated carrying local codes for the five levels of portage codes. After conversion, numerous complaints brought to the attention of our HCFA on-site representatives resulted in our establishing local codes to resolve the problem.

Based on our review, we feel that while it appears we did have some errors it is not of the magnitude that originally appeared in your review. Considering the enormous task this conversion created and the total number of codes that were converted the error rate would appear to be miniscule.

As soon as we receive HCFA's aproval on the ambulance and follow-up consultation procedure codes, we will take the necessary action to correct pricing.

Please feel free to contact me should you have any questions.

Sincerely,

/s/ LELIA WRIGHT
Lelia Wright
Division Manager
Medicare

LW/tb

bcc: Barbara Harvey

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing
Administration

Regional Office VI
1200 Main Tower Building
Dallas, Texas 75202

March 31, 1986

Our Reference: DPO-R6-3:MF
CP-COD-TBS

Ms. Lelia Wright
Medicare Division Manager
Texas Blue Cross-Blue Shield
Post Office Box 660156
Dallas, Texas 75266-0156

Dear Lelia:

This is in response to your letter of March 10, 1986 concerning pricing of procedures based on fees. Before the carrier takes any further action on the ambulance or follow-up visit codes, we would like to review the profile build and related data. Magda Flores will call you to set a date. If you have any questions, call her at 767-6441.

We appreciate your cooperation.

Sincerely,

/s/ JULIE MIEAR
for Lanny S. Day, Chief
Policy and Technical
Assistance Branch

January 28, 1986

Our Reference: DPO-R6-3:MF
CP-COD-TBS

Hilary H. Connor, M.D.
Deputy Commissioner for
Health Services
701 West 51st Street
Post Office Box 2960
Mail Code 600-W
Austin, Texas 78769

Dear Dr. Connor:

As a result of several indications to us that Texas Blue Shield had set fees where valid customary and prevailing data were available, we conducted a review of the fee setting process at the carrier. Based on our review, we have recommended to the carrier that they correct the pricing on the procedures listed in the attachment.

We appreciate your interest in this matter. If you have any questions, please call Carl Silvernail or Magda Flores at (214) 767-6441.

Sincerely yours,

Lanny S. Day, Chief
Policy and Technical
Assistance Branch

Enclosure

bcc: Steve McAdoo
Carl Silvernail
Official and reading files

PTAB/Mflores/mf f/1/28

Procedure Codes Which Require Action

1. 90060 — Eliminate fee. Load valid customary and prevailing data from 1-9005 into this code.

2. 90250 — Eliminate fee. Load valid customary and prevailing data from 1-9025 into this code.

3. 66983 — Eliminate fee. Load valid customary and prevailing data from 2-5620 into this code.

4. 66984 — Eliminate fee. Load valid customary and prevailing data from 2-5622 into this code.

5. A0220 — Eliminate fee. Load valid customary and prevailing data from 9-6012 into this code.

6. A0223 — Eliminate fee. Load valid customary and prevailing data from 9-6013 into this code.

7. 67908 — Eliminate fee. Load valid customary and prevailing data from 2-5727 into this code.

8. R0070 — Eliminate fee. Load valid customary and prevailing data from 4-7468 into this code.

9. R0075 — Eliminate fee. Load valid customary and prevailing data, if available, into this code.

10. W7451 — Eliminate fee. Load valid customary and prevailing data from 4-7451 into this code.

11. W7453 — Eliminate fee. Load valid customary and prevailing data from 4-7453 into this code.

12. W7460 — Eliminate fee. Load valid customary and prevailing data from 4-7460 into this code.

13. 74000 — Eliminate fee. Load valid customary and prevailing data from 4-7350 into this code.

14. 67143 — Eliminate fee. Load valid customary and prevailing data from 2-5635 into this code.

15. Z9072 — Eliminate fee. Load valid customary and prevailing data from 1-9072 into this code.

16. 51595 — Leave on fee. Ensure that the Economic Index has been applied to this procedure.

17. 33460 — Determine if the code this converted from profiled in FSY86. If so, compare current fee to this and bring back into line if it is different.

18. 90784 — If there were valid customary and prevailing data in the 1-9084, this data should replace the fee. If not, leave the fee and ensure that the EI has been applied.

19. 90798 — See above recommendation.

20. 52320 — Ensure that the EI has been applied. Otherwise, leave as is.

21. 95860 to 95864 — Leave as is.

22. M0702 to M0710 — Ensure that the EI has been applied. Otherwise, leave as is.

23. 78202 — Ensure that the EI has been applied. Otherwise, leave as is.

24. L6250 — Leave as is.

25. L6710 — Leave as is.

26. 67216 — Ensure application of EI. Otherwise, leave as is.

27. 67226 — Ensure application of EI. Otherwise, leave as is.

28. 67104 — Ensure application of EI. Otherwise, leave as is.

29. 67106 — Ensure application of EI. Otherwise, leave as is.

30. 67146 — Ensure application of EI. Otherwise, leave as is.

31. 93309 & 76629 — Ensure application of EI. Otherwise, leave as is.

32. 99171 to 99174 — Compare to RVU X PCF pricing. If it's in line, leave as is. Otherwise, make necessary adjustments.

33. 90640 to 90643 — Load the prevailing fee of the appropriate office visit code in each locality and specialty. Leave customaries to default pricing (50th percentile). If this is not feasible, array the prevailing charges for the office visit codes and select the 75th percentile.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

CIVIL NO. A-87-CA-688

TEXAS MEDICAL ASSOCIATION, ET AL

v.

OTIS R. BOWEN, ET AL

(Filed October 20, 1987)

ORDER

Before the Court is Plaintiffs' Motion for Temporary Restraining Order brought pursuant to Federal Rule of Civil Procedure 65. The Court has considered the Motion, supporting brief, affidavits, and Plaintiffs' oral arguments in support thereof. The Court has also considered Defendants' oral arguments in opposition to the Motion. Four criteria must be satisfied for Plaintiffs to be entitled to the issuance of a temporary restraining order. Plaintiffs must show: (1) a substantial likelihood that Plaintiffs will succeed on the merits; (2) a substantial threat that the Plaintiffs will suffer immediate irreparable injury if the temporary restraining order is not granted; (3) that the threatened injury to Plaintiffs outweighs the threatened harm to the Defendants; and (4) that the granting of the temporary restraining order will not disserve the public interest. *Enterprise International, Inc. v. Corporacion Estatal Petrolera Ecuatoriana,* 762 F.2d 464, 471 (5th Cir. 1985); *Sofranko v. Froehlke,* 346 F.

Supp. 1380, 1381 (W.D. Tex. 1972). The Court has reviewed all of the evidence available to it at this time and is of the opinion that Plaintiffs have failed to establish at least one of the four criteria.

Plaintiffs argue that there is a substantial threat of immediate irreparable harm if the temporary restraining order is not granted. Plaintiffs seek to enjoin Defendants from instituting any recoupment actions against the Plaintiffs pursuant to "the Overpayment Project" arising from alleged overpayments that were paid by Blue Cross and Blue Shield of Texas, Inc. with respect to certain claims made by Plaintiffs for Medicare Part B reimbursement for services rendered during 1985 and 1986. Defendants' attorneys made oral representations to the Court that no recoupment will be assessed until November 2, 1987. Based upon these representations of Defendants' attorneys, the Court is of the opinion that a hearing on Plaintiffs' request for preliminary injunction can be held and a ruling on the request can be made prior to the time that Plaintiffs will suffer any injury. The Court therefore finds that Plaintiffs have not shown that they will suffer immediate irreparable injury if the temporary restraining order is not granted.

ACCORDINGLY, IT IS ORDERED that the Plaintiffs' Motion for Temporary Restraining Order is DENIED.

IT IS FURTHER ORDERED that a hearing on Plaintiffs' request for preliminary injunction will commence at 2:00 p.m., Thursday, October 29, 1987. The hearing shall last two hours with the time equally divided between Plaintiffs and Defendants.

IT IS FURTHER ORDERED that the Court hereby imposes the following briefing schedule:

(1) Defendants shall submit a brief in opposition to Plaintiffs' request for a preliminary injunction, along with any supporting affidavits and documentary evidence, on or before Friday, October 23, 1987.

(2) Plaintiffs' shall submit any supplementary brief, along with any supporting affidavits and documentary evidence, on or before Monday, October 26, 1987.

SIGNED and ENTERED this 17th day of October, 1987.

/s/ JAMES R. NOWLIN
James R. Nowlin
United States District Judge

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

Cause No. A-87-CA-688

TEXAS MEDICAL ASSOCIATION, et al

v.

OTIS R. BOWEN, M. D., SECRETARY, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND BLUE CROSS-BLUE SHIELD OF TEXAS, INC.

October 29, 1987

Austin, Texas

TRANSCRIPT OF PROCEEDINGS

BEFORE THE HONORABLE JAMES R. NOWLIN

* * *

THE COURT: . . .

The court has reviewed the briefs in this matter, and also based upon that review and the arguments of counsel here this afternoon, it's the judgment of the court that the plaintiffs' motion for a preliminary injunction is well taken, and the court is going to grant that motion at this time.

The court, as it is required to do, viewing those four criteria, has done so. We will have a written opinion out on this expressing the court's formal findings, specific findings, hopefully, within five or six, seven days.

* * *

Court will stand in recess.

* * *

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

/s/ LYNN D. TITER

November 2, 1987

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

CIVIL NO. A-87-CA-688

TEXAS MEDICAL ASSOCIATION, ET AL

v.

OTIS R. BOWEN, ET AL

(Filed November 2, 1987)

ORDER

Before the Court is Plaintiffs' Motion for Preliminary Injunction. The Court has considered the Motion, Defendants' response, Plaintiffs' reply, and all of the supporting briefs, affidavits, and documents submitted to the Court. A hearing was held on the Motion on October 29, 1987, at which time the Court entertained the argument of counsel. Based upon all of the information before it at this time, the Court is of the opinion that Plaintiffs are entitled to the issuance of a preliminary injunction.

Defendant Otis Bowen asserts that the Court is without jurisdiction, and in the alternative, that Plaintiffs have failed to exhaust administrative remedies and are prematurely before the Court. The Court is of the opinion that both of these arguments lack merit.

The Court is keenly aware of the four criteria which must be satisfied for Plaintiffs to be entitled to the issuance of a preliminary injunction. Plaintiffs must show:

(1) a substantial likelihood that Plaintiffs will succeed on the merits; (2) a substantial threat that the Plaintiffs will suffer immediate irreparable injury if the preliminary injunction is not granted; (3) that the threatened injury to Plaintiffs outweighs the threatened harm to the Defendants; and (4) that the granting of the preliminary injunction will not disserve the public interest. *Enterprise International, Inc. v. Corporacion Estatal Petrolera Ecuatoriana,* 762 F.2d 464, 471 (5th Cir. 1985). The Court is of the opinion that Plaintiffs have met their burden on each criterion.

ACCORDINGLY, IT IS ORDERED that Plaintiffs' Motion for Preliminary Injunction is hereby GRANTED. Defendants are hereby ENJOINED from carrying out the program which they have denominated "the Overpayment Project" and from otherwise instituting recoupment actions against the Plaintiffs as a result of the alleged overpayments that were paid by Blue Cross and Blue Shield of Texas, Inc. with respect to certain claims made by the Plaintiffs for Medicare Part B reimbursement from July 1985 to March 1986.

IT IS FURTHER ORDERED that the preliminary injunction shall issue without bond.

The Court will shortly be issuing an order setting out findings of fact and conclusions of law in support of the granting of Plaintiffs' Motion for Preliminary Injunction.

SIGNED and ENTERED this 2nd day of November, 1987.

/s/ JAMES R. NOWLIN
James R. Nowlin
United States District Judge

APPENDIX E

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

CIVIL NO. A-87-CA-688

TEXAS MEDICAL ASSOCIATION, ET AL

v.

OTIS R. BOWEN, ET AL

(Filed January 11, 1988)

ORDER

Before the Court is Plaintiffs' Motion for Preliminary Injunction, as well as Defendant's response, and the supporting briefs and exhibits. A hearing on the Motion was held on October 29, 1987, at which time the Court orally granted Plaintiffs' Motion. An Order granting the Preliminary Injunction was entered on November 2, 1987. The following findings of fact and conclusions of law are entered in support of the Court's ruling.

The Texas Medical Association, Travis County Medical Society, Texas Academy of Family Physicians, Texas Opthalmological Association, Texas Society of Internal Medicine, and a number of physicians and patients have brought suit against Otis Bowen, Secretary of the United States Department of Health and Human Services (HHS), and Blue Cross and Blue Shield of Texas, Inc. (Blue Cross). Plaintiffs complain about Defendants' efforts to recoup monies that were paid to Plaintiffs in 1985 and

1986. Plaintiffs received these monies, Medicare Part B payments, for physician services rendered. Blue Cross is the carrier for HHS in Texas.

In July 1985, Blue Cross changed all of the codes for medical services from a Texas code to a federal code entitled HCFA (Health Care Financing Administration) Common Procedure Coding System (HCPCS). While making these conversions, Blue Cross encountered difficulty in matching the customary and prevailing charge data for 18 procedures to HCPCS codes. Therefore, Blue Cross chose to impose a statewide fee schedule for these procedures. HHS now claims that payments made under the fee schedule from approximately July 1985 to April or March 1986 were overpayments which they are entitled to recoup. Plaintiffs claim that the payments were proper and that Defendants cannot now recoup any portion of them. The recoupments at issue involve approximately 5,000 physicians, 15,000 beneficiaries, and an amount in excess of $13.3 million. While Plaintiffs seek certification of two classes, "the Nonassigned Beneficiary Class" and "the Assigned Physician Class," no class has been certified to date. Accordingly, the number of physicians and beneficiaries and the dollar amount involved in this cause at this time are less than stated above.

I. JURISDICTION

Defendants challenge the Court's jurisdiction over this controversy. Therefore, the Court will consider its jurisdiction before considering the merits of the Motion for Preliminary Injunction. Defendants argue that Plaintiffs' claims are in essence a disagreement over the amount of benefits and, therefore, this Court is without jurisdiction pursuant to *Bowen v. Michigan Academy of Family Phy-*

sicians, 106 S. Ct. 2133 (1986). Plaintiffs counter claiming that this dispute is a challenge to Medicare Part B reimbursement methodologies which *Michigan Academy* does not preclude federal courts from hearing.

In June 1986, the Supreme Court rendered the opinion of *Bowen v. Michigan Academy of Family Physicians,* which addressed "whether Congress, in either § 1395ff or § 1395ii of Title 42 of the United States Code, barred judicial review of regulations promulgated under Part B of the Medicare program." 106 S. Ct. at 2135. The Court noted a strong presumption that Congress intends judicial review of administrative action. *Id.* The earlier Supreme Court opinion of *United States v. Erika, Inc.,* 456 U.S. 201 (1982), held that Congress' failure to authorize anything beyond carrier review of determinations of the amount of Medicare Part B awards provided persuasive evidence that Congress deliberately intended to foreclose further review of such claims. *Michigan Academy,* 106 S. Ct. at 2138. The Court in *Erika* reached this conclusion after examining the language of 42 U.S.C. § 1395u(b)(3)(C) and §§ 1395ff(b)(1)(C) and (b)(2). In *Michigan Academy,* the Court again examined these statutes and deduced that the statutory scheme:

> simply does not speak to challenges mounted against the *method* by which such amounts are to be determined rather than the *determinations* themselves.

Id. at 21338. The Court concluded that:

> those matters which Congress did *not* leave to be determined in a 'fair hearing' conducted by the carrier—including challenges to the validity of the Secretary's instructions and regulations—are not im-

> pliedly insulated from judicial review by 42 U.S.C. § 1395ff.

Id. at § 2140. The Court further held that 42 U.S.C. § 1395ii which adopts 42 U.S.C. § 405(h) does not bar federal courts from hearing statutory and constitutional challenges to regulations promulgated by the Secretary of Health and Human Services. *Id.* at 2140-41. Defendants claim that Plaintiffs' challenge "does not fall within the ambit of *Michigan Academy* . . . because they have not challenged valid payment methodology which would have prospective effect on their reimbursement." Federal Defendant's Opposition to Plaintiff's Request for Preliminary Injunction, at 15. The First Circuit has ruled that *Michigan Academy* does not apply only to methodology challenges with a prospective effect, and this Court finds its reasoning persuasive. In *McCuin v. Secretary of Health and Human Services,* 817 F.2d 161, 165 (1st Cir. 1987), the First Circuit stated:

> One feature of the present case, distinguishing it somewhat from *Michigan Academy,* bears mentioning. In *Michigan Academy,* the relief requested was purely prospective; the present case, however, was brought by an individual whose already awarded benefits were at issue. McCuin, however, has not sought review of the merits of her Medicare claim. Conceding that § 1395ff bars her from making such an argument, she has solely contested the propriety of the Secretary's reopening procedure. *Michigan Academy* makes no distinction between purely prospective challenges and challenges which have arisen in connection with a past claim but which are directed solely at the 'method' of determination; nor does the Court's reasoning in that opinion give any grounds for making such a distinction.

Accordingly, the fact that Plaintiffs' challenge will not have prospective effect on their reimbursement does not remove it from the holding of *Michigan Academy*.

The Court is not convinced by Defendants' argument that this is a dispute over the amount of payment rather than the methodology of payment. Defendants' counsel agreed with the Court at the October 29, 1987 hearing that disputes which ultimately affect the amount a beneficiary or physician receives can be disputes over either amount or methodology. Accordingly, the fact that the dispute at issue affects how much physicians and beneficiaries receive does not mean that it is a dispute over amount rather than methodology.

Plaintiffs complain of Defendants' decision that the carrier's use of a statewide fee schedule for eighteen Medicare Part B procedures was improper. Defendants used the fee schedule for a period of approximately eight months in making payments to physicians and beneficiaries for these eighteen procedures. The fee schedule was phased out in March or April 1986. More than one year later, Defendants decided that payments made under this fee schedule were improper, and that monies needed to be recouped from physicians and beneficiaries. In Defendants' counsel's own words, "the defendant Medicare fiscal carrier[ ] use[d] . . . an invalid payment computation methodology for the period July 1985 through March 1986." Defendant's Opposition, at 1. This dispute centers upon whether the statewide fee schedule was a proper or improper payment methodology. As such, this Court has jurisdiction according to *Michigan Academy*.

Defendants also challenge jurisdiction on the basis that Plaintiffs have failed to exhaust administrative remedies.

Plaintiffs concede that administrative remedies must normally be exhausted before a dispute will be ripe for resolution by a federal district court. They argue, however, that the exhaustion doctrine is not absolute. The Fifth Circuit acknowledges the following exceptions to the doctrine:

> [*F*]*irst*, exhaustion is not required when the prescribed administrative remedy is plainly inadequate because either no remedy is available, the available remedy will not give relief commensurate with the claim, or the remedy would be so unreasonably delayed as to create a serious risk of irreparable injury. . . .
>
> *Second*, when the claimant seeks to have a legislative act declared unconstitutional and administrative action will leave standing the constitutional question, exhaustion is not required. . . .
>
> . . .
>
> *Third*, courts do not require exhaustion when the question of the adequacy of the administrative remedy is for all practical purposes co-extensive with the merits of the plaintiff's claim, such as when, for example, the plaintiff contends that the administrative system itself is unlawful or unconstitutional in form or application. . . .
>
> *Fourth*, exhaustion of administrative remedies is not required if it would be futile to comply with the administrative procedures because it is clear that the claim will be rejected.

Patsy v. Florida International University, 634 F.2d 900, 903-04 (5th Cir. 1981), *rev'd on other grounds*, 457 U.S. 496 (1982) (citations omitted) (cited with approval in

Hessbrook v. Lennon, 777 F.2d 999, 1003 (5th Cir. 1985)). Plaintiffs contend that the first and fourth exceptions apply.

The Medicare Part B hearing process is a plainly inadequate remedy according to Plaintiffs because it cannot give relief commensurate with the claim. Plaintiffs also assert that it would be futile to comply with the administrative process because their claims would be rejected. Plaintiffs contend that a Part B hearing officer is without authority to decide that Blue Cross' use of a statewide fee schedule was a valid payment methodology. Title 42, C.F.R. § 405.860 (1986) establishes the authority of a hearing officer as follows:

> The hearing officer in exercising the authority to conduct a hearing under section 1842(b)(3)(C) of the Act is to comply with all the provisions of title XVIII of the Act and regulations issued thereunder, as well as with policy statements, instructions and other guides issued by the Health Care Financing Administration in accordance with the Secretary's agreement with the carriers.

One guide is a compilation of instructions prepared by the Secretary and entitled the Medicare Carrier's Manual. The Manual provides, in pertinent part:

> The [hearing officer] may not overrule the provisions of the law *or interpret them in a way different than HCFA does when he disagrees with their intent;* nor may he use hearing decisions as a vehicle for commenting upon the legality, constitutional or otherwise, of any provision of the Act or regulations relevant to the Medicare Program.

Medicare Carrier's Manual § 12016 (1985) (emphasis added); *see also Michigan Academy,* 106 S. Ct. at 2138-39, 2139 n.6; *Medical Fund-Philadelphia Geriatric Center v. Heckler,* 804 F.2d 33, 38-39 (3rd Cir. 1986). Defendant Bowen has clearly enunciated his opinion, both in oral argument and in his briefs, that the statewide fee schedule is illegal. Accordingly, the hearing officer would be bound by the Secretary's interpretation that the statewide fee was improper and could not provide the Plaintiffs the relief they seek, namely stopping recoupments from Part B Medicare payments which were made under the fee schedule. The Court is persuaded by Plaintiffs' argument, and finds that exhaustion of administrative remedies is an unnecessary predicate to this Court's jurisdiction.

II. MOTION FOR PRELIMINARY INJUNCTION

Having resolved the jurisdictional issue, the Court moves on to the merits of the Motion for Preliminary Injunction. There are four prerequisites to Plaintiffs' entitlement to the issuance of a preliminary injunction:

> (1) substantial likelihood that the moving party will ultimately suceed on the merits; (2) irreparable harm if the injunction is not issued; (3) the threatened harm to the moving party will outweigh any potential injury the injunction may cause the nonmovant; and (4) the injunction will not disserve the public interest.

Lindsay v. City of San Antonio, 821 F.2d 1103, 1005 (5th Cir. 1987). The Court has examined each of these elements and is satisfied that Plaintiffs have borne their burden of proof.

A. *Substantial Likelihood of Success on the Merits*

Included in Plaintiffs' causes of action is a claim that Defendants have reopened Medicare Part B claims without authority to do so. If Defendants are without authority to reopen the claims involving the eighteen procedures for which payments were made from July 1985 to April 1986 based on the statewide fee schedule, then Plaintiffs will prevail.

The regulations concerning reopening are codified at 42 C.F.R. § 405.841 (1986), and provide:

> An initial or review determination of a carrier or a decision of a hearing officer may be reopened by such carrier or hearing officer:
>
> (a) Within 12 months from the date of the notice of such initial or review determination or decision to the party to such determination or decision; or
>
> (b) After such 12-month period, but within 4 years from the date of the notice of the initial determination to the party to such determination, upon establishment of good cause for reopening such determination or decision (see 20 CFR 404.958); or
>
> (c) At any time, when:
>
> (1) Such initial or review determination or decision was procured by fraud or similar fault of the beneficiary or some other person, or
>
> (2) Such initial or review determination or decision is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error or error on the face of the evidence on which such determination or decision was based.

The parties agree that subsection (b) requiring a showing of good cause for reopening applies in this case. The

disputed payments were made from July 1985 to April 1986 and recoupment efforts began in August 1987; therefore, a period of sixteen to twenty-five months is involved. Good cause is defined in section 12100.7 of the Medicare Carrier's Manual as follows:

> 'Good cause for reopening' under § 12100.2B exists where:
>
> A. New and material evidence is furnished;
>
> B. A clerical error has been made; or
>
> C. There is an error on the face of the evidence on which such determination or decision is based.

Defendants claim that new and material evidence that the payment methodology was erroneous has been furnished and that evidence establishes good cause for reopening. "New and material evidence" is also a defined term:

> *Meaning of 'New and Material Evidence'.*—Good cause exists for reopening a determination or decision within the period specified in § 12100.2B on the basis of new and material evidence even though the determination or decision when made was entirely reasonable based on the evidence then in file. New and material evidence includes any evidence which was not considered when the previous determination or decision was made and which shows facts that may result in a conclusion different from that reached in the determination or decision.
>
> It is also possible that the evidence may justify or even require further development be undertaken before a proper revised determination or decision is made.

Medicare Carrier's Manual § 12100.8A (1985). The Court is of the opinion that Defendants' discovery that the use of the fee schedule was erroneous is not new evidence within the meaning of 42 C.F.R. § 405.841(b), but a new conclusion drawn from previously available evidence. Plaintiffs assert, and the Court agrees that:

> No new evidence has surfaced that was not available or considered when the payment methodology determinations were made for claims submitted under the eighteen procedure codes. All information pertinent to the payment methodology determinations, including each Texas physician's historical customary charge data and the historical locality prevailing charge data, was available to [Blue Cross] and was considered by [Blue Cross] at the time the payment methodology determinations were made.

Plaintiffs' Brief in Support of Motion for Temporary Restraining Order, at 29. Accordingly, the Court is of the opinion that Defendants did not have good cause to reopen the determinations made for Medicare Part B payments for the relevant eighteen procedures from July 1985 to April 1986. Accordingly, the Court finds that Plaintiffs have established a substantial likelihood of prevailing on the merits.

B. *Irreparable Harm*

Plaintiffs argue two theories of irreparable harm: (1) damage caused to the doctor-patient relationship caused by the letters HHS sent to patients claiming that the physicians had been overpaid, and (2) permanent loss of any monies recouped because the doctrine of sovereign immunity will bar future recovery of money damages from the Defendants. At the October 29, 1987 hearing,

Defendants' attorney stated that they would not waive sovereign immunity. Transcript of October 29, 1987 Hearing, at 25. Defendants assert that if the Court determines that the payments made in 1985 and 1986 were proper, then Plaintiffs would have an available remedy. If those payments are not "overpayments" as Defendants claim them to be, then once the payments are reduced by recoupments, they would become "underpayments." Defendants state that they would then be obligated to increase the payments until they were no longer "underpayments." Defendants cite no regulations or statutes in support of this argument. The Court is not persuaded by Defendants' claims. The Court will not necessarily decide that the payments made in 1985 and 1986 were proper even if the Court ultimately determines that the payments cannot now legally be subject to Defendants' recoupment efforts. The Court may merely decide that Defendants have failed to show good cause for reopening the payment determinations. In that instance, Defendants could assert sovereign immunity if Plaintiffs tried to collect money damages for any amounts recouped by Defendants. Accordingly, the Court is of the opinion that Plaintiffs have demonstrated that the doctrine of sovereign immunity could cause them to permanently lose any monies now recouped. The Plaintiffs have met their burden of establishing irreparable harm.

C. *Balance of Harms*

Defendants argue that if a preliminary injunction issues, they will be harmed by delay in recovering funds that are rightfully theirs. They also claim that some physicians will no longer be participating physicians when this case is resolved. If Defendants prevail, these physicians will

not be submitting assigned claims against which the carrier can recover the recoupments. Therefore, costly individual litigation against these physicians could result. The Court is not persuaded that these threatened injuries to Defendants outweigh the injury to Plaintiffs in the absence of an injunction.

D. *Public Interest*

Defendants argue that the injunction would disserve the public interest by allowing Plaintiffs to retain public funds. The Court is of the opinion that the public would be disserved more in the absence of an injunction. The public will be harmed in the absence of an injunction by Defendants recouping money from citizens with the risk that the money is wrongfully recouped and would not later be recoverable. Accordingly, the Court finds that the injunction will not disserve the public interest.

In conclusion, the Court is persuaded that Plaintiffs have established the four factors necessary for the issuance of a preliminary injunction.

ACCORDINGLY, IT IS ORDERED that Plaintiffs' Motion for Preliminary Injunction is hereby GRANTED. Defendants are hereby ENJOINED from carrying out the program which they have denominated "the Overpayment Project" and from otherwise instituting recoupment actions against the Plaintiffs as a result of the alleged overpayments that were paid by Blue Cross and Blue Shield of Texas, Inc. with respect to certain claims made by the Plaintiffs for Medicare Part B reimbursement from July 1985 to March 1986.

IT IS FURTHER ORDERED that the preliminary injunction shall issue without bond.

SIGNED and ENTERED this 8th day of January, 1988.

/s/ JAMES R. NOWLIN
James R. Nowlin
United States District Judge

APPENDIX F

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 87-1970

TEXAS MEDICAL ASSOCIATION, ET AL.,
Plaintiffs-Appellees,

v.

LOUIS W. SULLIVAN, M.D., Secretary of Health and Human Services, ET AL.,
Defendants-Appellants.

Appeals from the United States District Court for the Western District of Texas

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ON PETITION FOR REHEARING

(July 27, 1989)

Before CLARK, Chief Judge, BROWN and JOLLY, Circuit Judges.

PER CURIAM:

IT IS ORDERED that the petition for rehearing filed in the above entitled and numbered cause be and the same is hereby DENIED.

ENTERED FOR THE COURT:

/s/ CHARLES CLARK
Chief Judge

APPENDIX G

STATUTORY PROVISIONS, REGULATIONS AND MANUAL PROVISIONS INVOLVED

42 U.S.C. § 1395ff (1985), Section 1869 of the Social Security Act

§ 1395ff. Determinations of Secretary

(a) Entitlement to and amount of benefits

The determination of whether an individual is entitled to benefits under part A or part B of this subchapter, and the determination of the amount of benefits under part A of this subchapter, shall be made by the Secretary in accordance with regulations prescribed by him.

(b) Appeal by individuals

(1) Any individual dissatisfied with any determination under subsection (a) of this section as to—

(A) whether he meets the conditions of section 426 or section 426a of this title, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter or section 1395i-2 of this title, or section 1819, or

(C) the amount of benefits under part A of this subchapter (including a determination where such amount is determined to be zero)

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final

decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

* * *

42 U.S.C. § 1395gg, Section 1870 of the Social Security Act

§ 1395gg. Payment on behalf of individuals

* * *

(c) Exception to subsec. (b) payment adjustment

There shall be no adjustment as provided in subsection (b) of this section (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1395f(e) of this title) with respect to an individual who is without fault or where the adjustment (or recovery) would be made by decreasing payments to which another person who is without fault is entitled as provided in subsection (b)(4) of this section, if such adjustment (or recovery) would defeat the purposes of subchapter II or subchapter XVIII of this chapter or would be against equity and good conscience. Adjustment or recovery of an incorrect payment (or only such part of an incorrect payment as the Secretary determines to be inconsistent with the purposes of this subchapter) against an individual who is without fault shall be deemed to be against equity and good conscience if (A) the incorrect payment was made for expenses incurred for items or services for which payment may not be made under this subchapter by reason of the provisions of paragraph (1) or (9) of section 1395y(a) of this title and (B) if the Secretary's determination that such payment was incorrect was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter.

42 U.S.C. § 1395u, Section 1842 of the Social Security Act

§ 1395u. Use of carriers for administration of benefits

(a) Authority of Secretary to enter into contracts with carriers

In order to provide for the administration of the benefits under this part with maximum efficiency and convenience for individuals entitled to benefits under this part and for providers of services and other persons furnishing services to such individuals, and with a view to furthering coordination of the administration of the benefits under part A and under this part, the Secretary is authorized to enter into contracts with carriers, including carriers with which agreements under section 1395h of this title are in effect, which will perform some or all of the following functions (or, to the extent provided in such contracts, will secure performance thereof by other organizations); and, with respect to any of the following functions which involve payments for physicians' services on a reasonable charge basis, the Secretary shall to the extent possible enter into such contracts:

(1)(A) make determinations of the rates and amounts of payments required pursuant to this part to be made to providers of services and other persons on a reasonable cost or reasonable charge basis (as may be applicable);

* * *

(b) Applicability of competitive bidding provisions; findings as to financial responsibility, etc., of carriers; contractual duties imposed by contract

* * *

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1395x(v) of this title);

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will (except as otherwise provided in section 1395gg (f) of this title) be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service, (II) the physician or other person furnishing such service agrees not to charge (and to refund amounts already collected) for services for which payment under under this subchapter is denied under section 1320c-3(a)(2) of this title by reason of a determination under section 1320c-3(a)(1)(B) of this title, and (III) the physician or other person furnishing such service agrees not to charge (and to refund amounts already collected) for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of section 1395y (a) of this title, and if the individual to whom

such service was furnished was without fault in incurring the expenses of such service, and if the Secretary's determination that payment (pursuant to such assignment) was incorrect and was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter (except in the case of physicians' services and ambulance service furnished as described in section 1395y(a)(4) of this title, other than for purposes of section 1395gg(f) of this title);

* * *

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

* * *

20 C.F.R. § 404.989

§ 404.989 Good cause for reopening.

(a) We will find that there is good cause to reopen a determination or decision if—

(1) New and material evidence is furnished;

(2) A clerical error in the computation or recomputation of benefits was made; or

(3) The evidence that was considered in making the determination or decision clearly shows on its face that an error was made.

(b) We will not find good cause to reopen your case if the only reason for reopening is a change of legal interpretation or administrative ruling upon which the determination or decision was made.

42 C.F.R. § 405.350

§ 405.350 Individual's liability for payments made to providers and other persons for items and services furnished the individual.

Any payment made under Title XVIII of the Act to any provider of services or other person with respect to any item or service furnished an individual shall be regarded as a payment to the individual, and adjustment shall be made pursuant to §§ 405.352 through 405.356, where:

(a) More than the correct amount is paid to a provider of services or other person and the Secretary determines that:

(1) Within a reasonable period of time, the excess over the correct amount cannot be recouped from the provider of services or other person, or (2) the provider of services or other person was without fault with respect to the payment of such excess over the correct amount,

* * *

(c) For purposes of paragraph (a)(2) of this section, a provider of services or other person shall, in the absence of evidence to the contrary, be deemed to be without fault if the determination of the carrier, the intermediary, or the Health Care Financing Administration that more than the correct amount was paid was made subsequent to the third year following the year in which notice was sent to such individual that such amount had been paid.

42 C.F.R. § 405.355

§ 405.355 Waiver of adjustment or recovery.

(a) The provisions of § 405.352 may not be applied and there may be no adjustment or recovery of an incorrect payment (i.e., a payment made under § 405.350 (a) or § 405.350(b)) in any case where such incorrect payment has been made with respect to an individual who is without fault, or where such adjustment or recovery would be made by decreasing payments to which another person who is without fault is entitled as provided in section 1870(b) of the Act where such adjustment or recovery would defeat the purpose of Title II or Title XVIII of the Act or would be against equity and good conscience. (See 20 CFR 404.509 and 404.512.)

(b) Adjustment or recovery of an incorrect payment (or only such part of an incorrect payment as may be determined to be inconsistent wtih the purposes of Title XVIII of the Act) against an individual who is without fault shall be deemed to be against equity and good conscience if the determination that such payment was incorrect was made subsequent to the third year following the year in which notice of such payment was sent to such individual. (See §§ 405.330-405.332 for conditions under which payment may be made for items or services furnished after October 30, 1972 which are noncovered by reasons of § 405.310(g) and (k).)

42 C.F.R. § 405.501

§ 405.501 Determination of reasonable charges.

(a) Except as specified in paragraph (b) of this section, Medicare pays no more for Part B medical and other health services than the "reasonable charge" for such service. The reasonable charge is determined by the carriers (subject to any deductible and coinsurance amounts as specified in §§ 410.152 and 410.160 of this chapter).

* * *

(e) Carriers will determine the reasonable charge on the basis of the criteria specified in § 405.502, and the customary and prevailing charge screens in effect when the service was furnished. (Also see §§ 405.480 through 405.482 and §§ 405.550 through 405.557, which pertain to the determination of reimbursement for services performed by hospital-based physicians.) However, when services are furnished more than 12 months before the beginning of the fee screen year (January 1 through December 30) in which a request for payment is made, payment is based on the customary and prevailing charge screens in effect for the fee screen year that ends immediately preceding the fee screen year in which the claim or request for payment is made.

42 C.F.R. § 405.502

§ 405.502 Criteria for determining reasonable charges.

(a) *Criteria.* The law allows for flexibility in the determination of reasonable charges to accommodate reimbursement to the various ways in which health services are furnished and charged for. The criteria for determining what charges are reasonable include:

(1) The customary charges for similar services generally made by the physician or other person furnishing such services.

(2) The prevailing charges in the locality for similar services.

(3) In the case of physicians' services, the prevailing charges for such services for fiscal year 1973 adjusted to reflect the cumulative economic index since calendar year 1971 but only if the charges so determined are not more than the prevailing charges determined under § 405.504(a)(2). The data used in determining the cumulative economic index should reflect changes in expenses of physicians' office practice and in general earnings levels.

* * *

(c) *Application of criteria.* In applying these criteria, the carriers are to exercise judgment based on factual data on the charges made by physicians to patients generally and by other persons to the public in general and on special factors that may exist in individual cases so that determinations of reasonable charge are realistic and equitable.

(d) *Responsibility of Administration and carriers.* Determinations by carriers of reasonble charge are not reviewed on a case-by-case basis by the Health Care Financing Administration, although the general procedures and performance of functions by carriers are evaluated. In making determinations, carriers apply the provisions of the law under broad principles issued by the Health Care Financing Administration. These principles are intended to assure overall consistency among carriers in their determinations of reasonable charge. The principles in §§ 405.503 through 405.507 establish the criteria for making such determinations in accordance with the statutory provisions.

* * *

42 C.F.R. § 405.841

§ 405.841 Reopening initial or review determination of the carrier, and decision of a hearing officer.

An initial or review determination of a carrier or a decision of a hearing officer may be reopened by such carrier or hearing officer:

(a) Within 12 months from the date of the notice of such initial or review determination or decision to the party to such determination or decision; or

(b) After such 12-month period, but within 4 years from the date of the notice of the initial determination to the party to such determination, upon establishment of good cause for reopening such determination or decision (see 20 CFR 404.958); or

(c) At any time, when:

(1) Such initial or review determination or decision was procured by fraud or similar fault of the beneficiary or some other person, or

(2) Such initial or review determination or decision is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error or error on the face of the evidence on which such determination or decision was based.

42 C.F.R. § 405.860

§ 405.860 Authority of the hearing officer.

The hearing officer in exercising the authority to conduct a hearing under section 1842(b)(3)(C) of the Act is to comply with all the provisions of title XVIII of the Act and regulations issued thereunder, as well as with policy statements, instructions and other guides issued by the Health Care Financing Administration in accordance with the Secretary's agreement with the carriers.

Medicare Carriers Manual § 7102*

7102. Determining Liability For Overpayments

Determine whether the physician or the beneficiary is liable for the overpayment. A beneficiary is always liable for an overpayment he received; however, HCFA may waive recovery if he is without fault *and recovery would defeat the purposes of Title II or Title XVIII or would be against equity and good conscience. Cases that may involve such circumstances should be examined in accordance with § 7116 for possible referral to HCFA.*

Where a physician has been overpaid, as the result of your clerical or computer error, fault is not an issue. However, the amount paid in excess of the correct amount is an overpayment and is to be refunded by the physician. In all other cases the physician is liable unless you determine that he was without fault with respect to the overpayment. There are very limited situations where § 1870 of the Act will be applicable; without fault will primarily involve § 1879 of the Act, coverage-type determinations.

If you determine that an overpaid physician was without fault, relieve the physician of liability for the overpayment. The beneficiary automatically becomes liable whether or not the beneficiary was at fault. (However, in the case of reasonable charge overpayments made to a without fault physician, refer the case to HCFA in accordance with § 7116.H. (See § 7103.1A.))

---

* The italicized words indicate language added to this provision by Transmittal No. 1316 from the Health Care Financing Administration, dated July, 1989, effective August 16, 1989.

Do not make decisions concerning beneficiary fault except in the case of overpayments arising from assigned claims for medically unnecessary services. Waive liability if you find both the beneficiary and physician without fault, i.e., take no action to recover the overpayment. (See §§ 7100C, 7115C, 7118A and 7300.5.) The question of beneficiary fault is considered by HCFA and the SSA program service centers in deciding whether to waive recovery from the beneficiary in the case of other overpayments. (See § 7118B.)

Medicare Carriers Manual § 7103.1A (Aug. 1983)*

7103.1 *Examples of Situations in Which Physician Is Liable For Overpayment.*—In accordance with the rules in §§ 7102 and 7103, the following are examples of situations in which the physician is liable for refunding an overpayment.

A. *The Overpayment Resulted From an Incorrect Reasonable Charge Determination.*—A physician is responsible for knowing the Medicare reasonable charge for his services. Therefore, he is generally at fault if he accepted a payment based on an incorrect reasonable charge. However, if the physician's reasonable charge screen was increased, and the physician had no reason to question the amount of the increase, the physician is not liable and the case is referred to HCFA in accordance with § 7116H. If on the other hand, the physician has reason to believe the increase was excessive, the physician is liable unless he or she brought the question promptly to your attention and you assured the physician that the increase was correct. In any case, the physician is considered at fault with respect to, and therefore liable for, any amount paid him which was more than 80 percent of his charge for the services.

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* Section 7103.1A of the Medicare Carriers Manual was amended pursuant to Manual Transmittal No. 1316 from the Health Care Financing Administration, dated July, 1989, effective August 16, 1989.

Medicare
Carriers Manual
Part 3—Claims Process

Department of Health and Human Services
Health Care Financing Administration

Transmittal No. 1316 Date July 1989

* * *

CHANGED PROCEDURES—EFFECTIVE DATE: 08/16/89

* * *

Section 7102, Determining Liability for Overpayments.—Changed to stress that "without fault" is applicable in very limited situations.

Section 7103.1 A., The Overpayment Resulted from an Incorrect Reasonable Charge Determination.—Changed to reflect that without fault is not an issue, that a physician is always liable and must return the erroneous payment.

* * *

Medicare Carriers Manual § 7103.1A (July 1989)

7103.1 *Examples of Situations in Which Physician Is Liable.*—In accordance with the criteria in §§ 7102 and 7103, the following are examples of situations in which the physician is liable for refunding an overpayment.

A. *The Overpayment Resulted From an Incorrect Reasonable Charge Determination.*—A physician is responsible for knowing the Medicare reasonable charge for his services. Therefore, he is liable to refund any excess payment based on an incorrect reasonable charge. If the cause was the result of clerical or computer error, fault is not an issue. In any case, the physician is liable for any amount paid him which was more than the correct amount.

Medicare Carriers Manual § 12016A

2016. HEARING OFFICER (HO)

A. *Authority*.—The HO occupies a significant position the administrative appeals process. Authority of the O is limited to the extent that he must comply with all rovisions of title XVIII of the Act and regulations issued ıereunder, as well as with HCFA rulings, general in- ructions and other guides. The HO may not overrule ıe provisions of the law or interpret them in a way ifferent than HCFA does when he disagrees with their ıtent; nor may he use hearing decisions as a vehicle for ommenting upon the legality, constitutional or otherwise, f any provision of the Act or regulations.

APPENDIX H

MEMORANDUM FROM BLUE CROSS TO HCFA
(Aug. 18, 1987)

BLUE CROSS
and
BLUE SHIELD
of Texas, Inc.
Post Office Box 660058
Dallas, Texas 75266-0058
(214) 669-6122

Rogers K. Coleman, M.D.
Vice President, Medical Director

Date 98-18-87

Phone No. 6122

To:
Steve McAdoo

Dept:
HCFA

From:
Dr. Coleman

Dept:
Medical Relations

Subject:
Recoupments Associated with Overpayments
Resulting from Conversion from Texas Codes
to Current Procedural Terminology

There may be some embarrasment associated with the current special recoupment program specifically related to the cataract surgery codes, 66983 and 66984. There was an unusual amount of confusion in the conversion of these two codes. Some of the elements contributing to this confusion were:

— the descriptions of Texas codes 5620 and 5622;

— the original conversion in 1984 of both codes to CPT 66980, the only cataract with intraocular lens implant available in 1984;

— subsequent conversion of
5620 to 66984
5622 to 66983.

In retrospect this was not an accurate match. The language in CPT 1985 did not lend itself to a more accurate decision at that time. CPT 1987 leaves no doubt that

5620 should go to 66983
5622 should go to 66984

The Texas Carrier, in response to numerous complaints of erroneous payments being made in the summer of 1985 (subsequent to the conversion) made a decision (with Regional Office support) to display similar profile history under 66983 *and* 66984. This was an interim step to temporarily solve the reimbursement errors that occurred earlier in 1985.

It is my belief that doctors actually performing 5622 in 1983 and 1984, and having operative notes supporting that the same procedure was performed in 1985 and early 1986, were not truly overpaid. The illusion of overpayment occurs because of mismatching 5622 to 66983 and the associated confusion in Customary, Prevailing and 50th percentile profiles and the MAAC as a result of the mismatch.

If this is, indeed, a correct reconstruction of events, many of the "overpayments" for 66983 (and perhaps 66984) are illusions and not real. Ignoring the facts and forcing these opthalmologists into Fair Hearings will be not only embarrassing but wrong and damaging financially to some of them.

The responsibility for the conversion process—and its errors—was to a very great extent my own. Under these circumstances my discomfort level is *very* high. I respectfully request that the September 4, 1987 deadline for recoupment/offset for 66983 and 66984 be extended until the matter can be given further study to establish, in fact, the sequence of events surrounding the conversion of 5620 and 5622 to 66983 and 66984.

Your consideration and counsel is appreciated.

/s/ RKC

RKC/paj